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PRESCRIPTION DRUG COSTS: A BITTER PILL TO SWALLOW

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS

AND THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

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PRESCRIPTION DRUG COSTS: A BITTER PILL TO SWALLOW

MONDAY, SEPTEMBER 28, 1992

**U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING, JOINT WITH ITS
SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS,
*Washington, DC.***

The Committee and Subcommittee met, pursuant to notice, at 3:30 p.m., at the Holiday Inn, U.S. Route East, Logansport, Indiana, the Honorable Jim Jontz, presiding.

Members present: Representatives Jontz and Costello.

Staff Present: Phil Jacobs, Conference Coordinator, Representative Jontz's staff.

STATEMENT OF REPRESENTATIVE JIM JONTZ

Mr. JONTZ. I call to order this hearing of the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging and welcome all of you this afternoon. In a minute, I'm going to introduce my co-chair for the hearing, who is a Congressman from the 21st District of Illinois, Jerry Costello. I want to take a minute at the beginning to express my appreciation to the witnesses who are with us today. We're going to hear a great deal of interesting testimony this afternoon, and thank all of you for your interest in this very important subject, which is prescription drug costs and what we can do to get them under control.

I am the only member from the Congressional delegation in our State who is a member of the Select Committee on Aging in the U.S. House of Representatives. I asked if it would be possible for the Committee to have this field hearing on the cost of prescription drugs because I'm increasingly concerned that it is necessary for the Congress to take action to see some controls on these escalating costs. It's no exaggeration to say that prescription drug costs are a very major burden on a number of the residents of our country, and certainly residents of the Fifth Congressional District. We will hear from citizens this afternoon who will speak personally to their experience with regard to the decisions they have to make in order to be able to afford the prescription drugs that are necessary for their health.

In 1991, our nation spent almost \$700 billion on health care, and of that, over \$32 billion was for prescription drugs, not including drugs provided in hospitals. During the 1980's, prescription drugs went up just about three times the rate of inflation, and they continue to increase. The Senate Aging Committee reports that an av-

erage \$20 prescription in 1980 now costs \$53.76 and will reach \$120 by the year 2000, a 600 percent increase, if something is not done.

Meanwhile, the pharmaceutical industry reports an annual profit average of 15.5 percent, which is more than triple that of the average Fortune 500 company. Efforts have been made to put controls on the costs of prescription drugs for the Medicaid program and for other aspects of health care, but it's very clear that traditional efforts need to be made in order to see that prescription drugs are kept affordable to all of the citizens of our country.

This afternoon's hearing will be an opportunity to collect information which we hope will be helpful to the Committee on Aging. The Committee on Aging is a committee which does not have specific legislative jurisdiction, meaning that our responsibility is not to write legislation per se, but rather to conduct investigations, to receive testimony, to make recommendations which are then of use to the other committees in the Congress, the difference being that our focus is very specifically on the problems affecting retirees and senior citizens in our country. This information we'll collect this afternoon I think will be helpful as the Congress looks at the issue of health care, what can be done overall to deal with health care costs, and specifically, to deal with the costs of prescription drugs.

I want at that time to introduce my colleague, who is a member of the Committee as well as myself, and he has travelled from his district in Western Illinois, where both of us were this morning at the city of Fairview Heights, where we conducted a hearing on the subject of medical fraud and how that costs consumers and the taxpayers, and I'm delighted to welcome Congressman Jerry Costello to the Fifth District of Indiana. Jerry is a legislator who feels very strongly about issues affecting the elderly, and I'm delighted you could make this trip to Indiana. We welcome you, and I'd like to recognize Congressman Costello for whatever statement he may make at this time.

[The prepared statement of Representative Jontz follows:]

OPENING STATEMENT OF
REPRESENTATIVE JIM JONTZ

"PRESCRIPTION DRUG COSTS:
A BITTER PILL TO SWALLOW"

Good afternoon and thank you all for coming to what I believe will be a very informative hearing on the critical issue of the rising costs of prescription drugs. I want to also thank my distinguished colleague from Illinois for joining us in our beautiful district for this hearing. Representative Costello is a strong supporter of programs that serve the elderly and of providing better health care for all Americans.

It is no exaggeration to say that prescription drug costs are out of control and that millions of Americans, both young and old, are being forced to make decisions on whether to purchase the prescription drugs that they need or pay their other bills and buying food and clothing. This is unacceptable to me and I will work in Congress to tame these rising costs and provide the necessary coverage for prescription drugs for those who cannot afford them.

The purpose of this hearing is to examine the rising costs of prescription drugs and how changes in the way the Federal Government purchases drugs for Medicaid and other programs have affected the cost of these drugs to other purchasers. We will hear from older consumers of prescription drugs, health care providers, advocates for the elderly, and from a local manufacturer of pharmaceuticals.

Before I turn to my colleague for his remarks and the witnesses, I would like to frame this hearing with a little background information that shows the importance of our discussion here today. In 1991, our Nation spent \$665 billion dollars on health care, and over 32.3 billion of that total was for prescription drugs, not including drugs provided in hospitals.

This is a lot of money being spent on prescription drugs, and they may be necessary to cure the ills that we face. But the prices that we pay have simply gone out of the roof. They are rising faster than the rate of inflation for medical services and all items purchased by consumers. The fact is that manufacturers hiked their prices 152 percent during the 1980's, and during 1989 - 1990 alone prices for prescription drugs went up 10 percent. Inflation for prescription drugs continues to rise, and in 1991, they went up 11.2 percent. I do not think many of my constituents will be able to handle these kinds of increases much longer. In fact, many of us won't be able to afford the drugs we need or the insurance to cover the drugs if these trends continue.

So that we all understand what this means to the average consumer, let me provide a couple examples. The Senate Aging Committee reports that an average \$20 prescription purchased in 1980 now costs \$53.76 and will reach \$120.33 by the year 2000, a 600 percent increase. Who pays for all this inflation? The consumer pays. The large majority (72.4 percent) of prescription drugs are paid for out-of-pocket by consumers. And for three out of four Older Americans, these drug costs are your largest out-of-pocket health expenses.

Remember, this cash goes to the drug industry which reports an annual profit average of 15.5 percent. This is more than triple that of the average Fortune 500 company. Today I would like to talk with the people of Indiana about whether or not we can afford to let the system stay as it is.

I want to make it clear that Congress has made some attempts to hold back some of the rising costs of prescription drugs, and we will continue to do so. But we may need the strong support of individuals and advocacy groups, and other segments of the health care field in order to work for a fair system, and pharmaceutical manufacturers will not let us do this without a fight.

Again I want to thank everyone for coming this afternoon. I hope we have fruitful discussions with all of our witnesses and as Members of Congress, we will take your thoughtful concerns back to Washington and put them to good use.

STATEMENT OF REPRESENTATIVE JERRY F. COSTELLO

Mr. COSTELLO. Thank you for inviting me to your district for this hearing on prescription drug costs. As Congressman Jontz just stated, our nation spent over \$32 billion on prescription drugs last year, excluding drugs provided during hospital stays. Some seniors are not taking their necessary medication due to the great expense involved, and it's a tragedy. I want to thank Congressman Jontz again for his leadership in organizing this hearing. I look forward to hearing the witnesses that are scheduled to testify before this committee, and I can assure everyone here that the Chairman and I will take the testimony and the proceedings of this hearing today and share that information with our colleagues on the Select Committee on Aging. Thank you.

Mr. JONTZ. Thank you, Congressman Costello. Let me at this time ask our first three witnesses, if they would, to assume their seats, and I am going to give you the choice as to whether you wish to testify from the seat there or from the podium. You may feel more comfortable testifying at the table, although I'm not sure that the sound system works as well, but I'll leave that choice to you. Let me introduce the three individuals, and then—excuse me, four individuals. The four individuals who are on our first panel, and then I will ask them to proceed with their statements.

First, Joe Scionti of Kokomo, who is here as a consumer who has experienced high prescription drug expenses. Then following him will be Pansy Jamison from the town of Sidney, Indiana. I have to tell you that I met Pansy when I was going door to door in Sidney, and I was very impressed at how articulate she is on the subject, and I appreciate her willingness to participate today, too. Then Billie Joe Enyeart, who is from Marion, also a consumer. Then Geri Malone, who is an R.N. and a public health nurse for Howard County Public Health Department. We'll also offer her perspective on this consumer panel.

Phil, do we need to help move the microphones? Is that going to be necessary in order to properly—

Mr. JACOBS. I would be better to have them testify at the podium. Otherwise, we'll have to move both mikes around.

Mr. JONTZ. Well, I think we should move both mikes. I really think it's—would you prefer to testify at the table or the podium?

Mr. SCIONTI. Personally, I would at the table.

Mr. JONTZ. Okay. Let's just move the mikes. It will be a little cumbersome, but I think the witnesses will feel more comfortable that way, and if we would just ask the audience to be patient with us while we do this. Thank you very much, and please proceed.

STATEMENT OF JOE SCIONTI, KOKOMO, IN

Mr. SCIONTI. My name is Joe Scionti. I'm from Kokomo, Indiana. I'm 70 years old. You probably have been reading all kinds of statistics about drugs—magazines, newspapers, radio, television, whatever. You've heard some statistics that Congressman Jontz has been quoting. I have some statistics from the Health Care Financing Administration. They say that in 1980 in this country, we spent \$250.1 billion, or about 9 percent of our gross national product, on health care. That's in 1980. That meant \$1,063 per capita. In 1990,

we spent \$666.2 billion, or 12 percent of our GNP. Now that became \$2,566 per person. They are projecting that in the year 2000, we will spend \$1.8 trillion, or 16 percent of our GNP, which amounts to \$5,712 per capita. Now, that's a lot of money, folks. That's a lot more money than many of our people in Indiana can afford to spend.

Now, of those numbers I just gave you in 1980, \$21 billion of it went for drugs. In 1990, that \$21 billion became \$54.6 billion, and now they're projecting that in the year 2000, it will be \$91 billion. So, from 1980 to the year 2000, we have gone from \$21.6 billion for drugs to \$91 billion potential in the year 2000.

Now, a recent study was done at the University of Pennsylvania Law School, and it showed that in the year 1991, 50 percent of all the individual bankruptcies were caused primarily by medical expenses. Eighty percent of the bankruptcies, individual bankruptcies, had medical expenses as part of the listing of the debts in those bankruptcies.

I was feeling pretty bad about my individual personal expenses until I caught a segment of "60 Minutes" last night on television, and they had on that program, in person, real people who talked about their medical and drug expense. They had a young boy who was a hemophiliac, and he had contracted the disease—in addition to the hemophilia, he got HIV because of the blood clotting agent which he was using. It costs them \$1,000 for a small bottle about this big for one treatment for that boy. Over the year, over 1 year, a hemophiliac can spend \$200,000 for prescription drugs. Since in this particular instance he also had HIV, they added another \$50,000 in costs.

Now, I don't know about Congressman Jontz and Congressman Costello, whether they could afford to pay those kind of costs, I don't think so. I know I can't. I know none of you here can, and we're talking about 1 year, folks. One year, \$250,000. Do you know what we're being forced to do? You either have to be a prince or a pauper to get medical assistance in the United States today. Some of these folks, this particular family, is considering not only bankruptcy, but they are considering getting divorced. Do you know why? Because if they get divorced, then she becomes eligible to get Federal assistance, and if they get rid of their assets to a certain extent—I think now you can have \$1,800 or something, some big amount like that—then you can get on Medicaid, and Medicaid will pay these expenses.

Well, as I look around here folks, I don't see the paupers, and I really don't see the princes, either. So, here we are, the middle income people, we have to pay these bills, and we're not getting any help doing it. We're certainly not getting any help from the drug companies. If they have an income of 15 percent, do you know what you're getting on your bank accounts today? Two percent maybe, 3 percent, and they're turning over 15 percent.

If you read the statement which they're going to be issuing today, they're going to tell you how they're spending all this money on R&D, that's research and development. Are they really spending the money on R&D? Ask them what they're top level people are getting in salaries. As them about the bonuses that are being paid. Ask them about the medications that are less than 10 years

old which they're still getting the same—the cost of those medicines has gone up 300 or 400 percent, but it's the same materials they were using before.

All right, let's get back to why I'm really here for me, just for me. I feel embarrassed to talk about my medical expenses when we talked about these people who are spending \$100,000 a year or \$50,000 or 10,000. You know what my—I look at it now, and it's meager, but to me it's not meager. I have to pay these. My wife and I are spending monthly—now here are the drugs. Listen to the litany of the drugs. Naprosyn, Provara, Ogen, Vasotec, Caridzem, Prozac, Clonopin, Lasex, Capitan, Lanoxin—aren't those really clever names? Listen to all of those beautiful, clever names. Do you know what we're paying for those? The Naprosyn is \$55.70.

You know, it's a lot of fun for me in Kokomo, Indiana when I go to the drug store and I'm standing in line, and there are three people ahead of me who work for General Motors, and they pay \$3 for a prescription. I'm not knocking the unions, folks. I say hey, that's great for you, but I stand behind the guy who puts down \$3, and for the same prescription, I pay \$55.70. Provara, \$11.39. Ogen, \$17.59. Vasotec, \$31.40. Cardizem, \$31.69. Prozac, \$49.79. Clonopin, \$38.99. That's per month. That is per month.

Now, let me tell you a little funny story. We have a dog. My dog is 14 years old. She's a member of our family, she has been. That dog has been very loyal to us, and we love that dog. A year ago, that dog suffered a congestive heart problem, and so I have to buy medication for the dog. Either that or send the dog to be put away, but I'm not going to do that. There are some people I know that I probably would do sooner than I would that dog. At any rate, if I throw the dog into this, I'm paying \$23.48 for the dog monthly, \$32.40, and \$6.29, or \$62 a month to keep my best friend, that dog, Jessy Lou. Yes, I'm going to keep her. I'm going to do without other things, but I'm going to keep her.

So, altogether, folks, and like I say, I'm almost embarrassed to say the number, I'm spending about \$400. Well, that's \$4,800 a year, and I'm on Social Security. You know, that's that large amount that we've been contributing to every payday. We've contributed for years and years and years. Well, I know it wasn't meant to be a total retirement program, but I'm living on that Social Security. My wife is not employed, and \$4,800 a year is almost that \$5,000 which I wish I didn't have to pay. Every time I go to that drug store—you know what, I go to Phar-mor because it's cheaper than any other drug store. Every time I go there, every 2 or 3 months suddenly these prescriptions costs 50 cents more. Oh, I'm sorry, but that is now 75 cents more. This one is 80 cents more. So, this \$400 a year from now may be \$450. Two years from now, who knows what it will be, but I know in the year 2000 Lord, I may be dead, so I won't have to worry about that.

Something, gentlemen, must be done about prescription drug costs. It has to be done. There are people suffering in this country that can't afford the drugs. Some of them are giving up a lot of things just to pay for their drugs, and some of them are not taking the drugs because they can't afford to take them, and they're in pain and they're suffering. I hope that the men who stand by the

Potomac River are listening and will have the courage to stand up and say we're here to do so. We're going to help.

Thank you. That's all I have to say.

Mr. JONTZ. Thank you. That's why we're conducting this hearing, and we thank you, Mr. Scionti, for your statement, and Mrs. Jamison, please proceed. I'm going to ask Mr. Jacobs on my staff to move the microphone down to make sure that we can hear you the way we want to.

STATEMENT OF PANSY JAMISON, SIDNEY, IN

Ms. JAMISON. My name is Pansy Jamison, and I live in Sydney, Indiana. My husband died in 1965, and after he died, I was in the hospital about five different times, first gallstones and then other things, hysterectomy and a lot of other things. If I wouldn't have had awful good insurance at that time, I wouldn't have a roof over my head.

Now, I am on a fixed income, and I get \$632 a month. Out of that \$632 a month, I pay \$184 a month for Blue Cross and Blue Shield. Now, here comes the other. I go into the doctor's office, and it's \$31, whether he does anything or not. Just to walk through that door into his office, it's \$31. Anything else is extra. He gives me my prescription, and I've got heart trouble, arthritis, I have to take thyroid medicine, and high blood pressure.

So, here's the prescription for Procardia. That's for the heart, \$106.81. Here's a prescription for Kaon, \$56.95. Here's a prescription for Capoten. Now, that's for blood pressure, \$90.04. That's after you get the senior citizen's deduction. Here's another Procardia, \$108.39. Capoten, \$90.04. Now, that all comes to, when I buy pain medicine, which I will take a whole bottle of Tylenol, and I get the big size, they are \$15. Then I've got to take a bowel softener because I've had a hemorrhoidectomy, and I have to take that every night. Altogether when I buy all of this medicine at one time, is \$315.

Now, you subtract that—besides all of this non-prescription medicine, and see what you've got left to live on. There's electric. The electric bill runs around \$31.50, and I don't have any automatic washer or nothing like that. I have a phone, and that's \$22.58. I carry a life insurance because the one I've got, the paid up policy from Lafayette, wouldn't be enough to bury me, \$3,000. So, I take out another policy from J.C. Penney, and that's \$21.17 a month.

So, you figure up what you've got left to live on. I have the Social Security, the Railroad retirement, combined, which comes to \$632.

Mr. JONTZ. Thank you. Thank you for your statement. We will now recognize Billie Jo Enyeart, and Ms. Enyeart, we have a written statement from you, and it will be included in the record along with the attachments. If you wish to read the statement, you're welcome to do that, or summarize it, either one, whichever you prefer.

STATEMENT OF BILLIE JO ENYEART, MARION, IN

Ms. ENYEART. I was going to read it, but I've changed my mind. I'm going to go through it a little bit. My name is Billie Jo Enyeart. I'm 51 years old. I'm not a senior citizen yet, but I'm certain-

ly on the way. I'm from Grant County. I and many others are victim of this health care system and prescriptions. I do take a lot of prescriptions, which I have enclosed, if whoever has my flyer. My prescriptions run \$322.44 a month. I'm drawing unemployment right now, which is \$464 a month. My rent is \$285. I have a budget electric bill which is \$65, and a phone. So, you know what that leaves me to live on? Zero, because my income is \$464. Just those that I mentioned is \$504.18, which does include a car payment. That leaves nothing else.

I've had insurance most all of my life and was never sick, and now that I am sick, I don't have insurance. I don't have any way to get my medicine. My doctor gives me blood pressure. I'm taking blood pressure pills right now and water pills, only because he gave me a 30-day free supply. Otherwise, I would not be taking them. The rest of my medicine, which is arthritis medicine, I take Fena-profin. I take Zantac because I have so many reactions. I am allergic to 25 medications. The Zantac is \$122.88 a month. That's for a 30 day supply. I also take an estrogen. I take a pain pill, and I take a stress pill, and it's no wonder I take a stress pill with all of this. I don't know where I am going. I know that I need health coverage not just for prescriptions. I see my doctor again in 4 months. I have 14 unemployment checks left, and I don't know what I'm going to do. You know, at this time it's very sad.

All my life, I've paid in money, taxes, and insurance, and I've worked since I was 15 years of age and until basically 1987, when I did become very ill, and then my bottom dropped out of my world. My prescriptions were even more money than what I ever dreamed in my life would be, and who knows what tomorrow is going to bring if we don't do something about this prescriptions rising and rising, the doctors, the insurance. I just don't know what we're going to do, but I do know one thing. I'm not ready to die yet, and I'm not going to, and if I should, there's going to be a lot of people hear about me before I do. Thank you.

[The prepared statement of Billie Jo Enyeart follows:]

September 28, 1992

Good afternoon Ladies and Gentlemen:

My name is Billie Jo Enyeart, I am 51 years old, I am from Grant County, Marion, IN. I have a high school diploma.

I and many others are victims of the health care systems. I have worked in the medical profession for approximately 24 years.

In 1979 and 1981 I received a back injury, which left me with a perement lower back problem, which now has arthritis and must be treated.

In 1984 after several months of breathing problems, I went to the ER/was diagnosed with asthma/was treated. I had a severe reaction to the medicine given. I had contacted several physicans but was not accepted as a patient, because I had no insurance and no way to pay for services.

In 1985 after months of pain and sleepless nights, unable to function as a human being, I found a physican to accept me on a cash basis. I was diagnosed as having arthritis.

In 1987 as the arthritis progressed, I was sent to a specialist. At this time I had insurance. I was treated with medication. I had a delayed reaction to the medication, and went to the ER and was nearly unconscious. I am alergic to 25 differnt medicines.

In 1988 I suffered dizziness, severe headaches, blurred vision and weakness of the limbs. Since I had no insurance and could not find a physican, I suffered pure agony for several months. I was unable to walk or get up or down without help, my joints were so swollen. Finally the Trustee sent me to a physican who did not treat me correctly for extremely high blood pressure. I proceeded to get worse daily, until I refused to be treated by him again. I contacted my Trustee and was not premitted to see another physican at the Trustee's expence, though they were reimbursed by Medicaid and I and family members also worked community hours to pay for this. I had applied for Medicaid in Dec. of 88 and it went through April of 89. Before Medicaid became effective I became so ill, my sister became so concerned that I might die. She called her personal pyhsican, Dr. Economan, told him about my situtation and my health.

He agreed to see and treat me at no charge. My blood

pressure was at a life threatening high, my medicine was changed, I did not improve and I was put in the hospital six days later. I was also physically and mentally exhausted trying to find a way to pay for my medications, until Medicaid became effective.

In 1989 I had sinus surgery and it was discovered I had several pollyps, which were removed. I was told the process would to be repeated in a few years.

At this time my 10 monthly medicines are in excess of \$325.00, but I am only taking 2 B.P. and my water pills because Dr. Economan gave me a free 30 day supply. I can not purchased the other much needed medicine. (SEE ATTACHED SHEET)

My doctor includes and I quote - "If she does not continue on her medicine, I think this could be life threatening ." (SEE ATTACHED LETTER)

I have applied for medicaid since I am now without insurance. As much as I wish for Dr. Economan to be my physican - I do understand he can't see me free of charge, I have no way to pay him at this time.

Many people are in the same or simular situtations that I have spoken to, have thought about suicide, including myself, because of the worry, stress, pain and illness that is suffered and the emotioal burden put upon the family and friends, also with the possibilities of what could happen in the future without assistance.

I as a concerned citizen, feel all people deserve the right to NATIONAL HEATH CARE, employment should not be the key to health care.

Also attached is some 1990 census and statistics for Grant County.

Thank you for your time,

Billie Jo Ehyeart
Billie Jo Ehyeart



**MARION
FAMILY
PRACTICE, INC.**

James E. Botkin, M.D.
Miles W. Donaldson, M.D.
Dale W. Economan, D.O.
Calvin Russell, M.D.
Jeffrey W. Bragg, D.O.
Mark A. Westfall, M.D.

July 22, 1992

RE: BILLIE JO ENYEART

To Whom It May Concern:

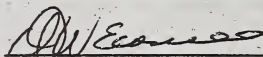
Mrs. Enyeart is under medical treatment for degenerative arthritis, peptic ulcer disease, chronic back dysfunction, hypertension and hypertensive cephalgia. She currently takes Hytrin 5 mg. one daily and Vasotec 5 mg. daily, and Lasix 20 mg. q.am and Elavil 75 at bedtime and Premarin 0.9 daily, ~~and~~ 150 b.i.d., Nalfon 600 4 times daily, Darvocet N 100, 3 daily as needed for pain control.

Mrs. Enyeart has restrictions for lifting, bending, twisting and standing due to her chronic low back dysfunction and arthritis. She is extremely hypertensive and if she does not continue on her medications I think this could be life threatening to her.

Please contact me if I can provide any further information regarding her medical condition.

Sincerely,

Marion Family Practice, Inc.


D. W. Economan, D.O.

DWE/rm

Brought in
6-12-92

June 9, 1992

Dab Huaks

I need a list of the cost
for my medicines for a
30 day supply, not a list of
when I brought them. Here
is what I take:

122.88	Zantac 150 mg	one tab three times a day
42.64	Fenpropofen 100 mg	1 tab 4 times a day
11.06	Amitriptyline 75 mg	1 tab at bedtime
18.02	Premarin 0.9 mg	1 tab a day
50.78	Paracetamol 100	8 tabs a day
29.21	Vasotec 5 mg	1 tab daily
43.56	Hytrin 5 mg	1 tab daily
4.99	Furosemide 20 mg	1 tab daily

HOOK DRUGS #120
321 W. 3RD STREET
MARION, IN 46952

RHB—2

#322.44

Thank You Very Much

Billie Jo Emyard

P.O. Box 6112

1606 1/2 W. Jefferson

Marion, Indiana

11605-2

Phone
317-651
0836

Mr. JONTZ. Just so that I have the proper title for Geri Malone in the record, she is the nursing coordinator for the Howard County Board of Health. Is that correct, Jerry?

Ms. MALONE. That's correct.

Mr. JONTZ. Thank you, and please proceed with your statement.

STATEMENT OF GERI MALONE, R.N., HOWARD COUNTY PUBLIC HEALTH DEPARTMENT

Ms. MALONE. I was invited to come to your hearing. I come to you as an advocate for the nearly poor population, and as I sit here and listen to these folks giving their story, I think they are probably in that category. The nearly poor person doesn't qualify for Medicaid. In my experience working in the Health Department, I'm going to bring in families and children into this. That person usually has a minimum wage, and probably there's two people working in the family. They may also have two to three children. They may use resources, public health resources, that I have in my department, such as a healthy children, well child clinic, and immunization clinic. Their income being minimum wage does not usually, it barely covers their existence. In Kokomo, Indiana, you can barely rent anyplace for under \$300. At minimum wages, they get no health benefits, and you know in Kokomo, as you go through, we are loaded with fast food restaurants. Well, these are all the people that are supporting that business with their employment.

If any one of these two to three children becomes ill or has a chronic situation or has a hospitalization, that right away puts them in a situation where they already can't afford medical care. Then on top of that, they can't afford medical care prescriptions. Well, that's impossible. These people's income only pays for food, rent and utilities, and then after that, health care is a secondary thought, and also prescriptions.

I think I also represent the plight of rural metropolitan areas such as Kokomo with a population of about 80,000. Somehow it seems to me in my work that bigger cities such as Ft. Wayne and Indianapolis have more ability to help their people, whereas we have less ability. We're dependent on county resources and dependent on some grants, if we're able to do that. Right now in Howard County, we have a primary health care crisis. We don't have enough family physicians for patients. We don't have enough pediatricians. We only have four pediatricians for 80,000 people and four O.B. doctors. So, families and children are very definitely being slighted in our county, and I don't think this is unusual. It's very difficult. The hospitals, it's a wonderful county, but the hospitals are having difficulty attracting physicians.

So, what I'm bringing to you today is information on our health children's clinic and also information from the United Way information and referral office of Howard County, which, when people can't get money anyplace else, they go there. Laurie Tate, who is the director, talks to different churches and tries to get money, and I have verification of the money that they spent on prescriptions. Those people include older adults. They include families, and they include children. Healthy children and well child clinic, the information I'm going to give you just includes that well child clinic,

ages 2 weeks to 6 years. The third source I have is the Sutter Township trustee's office in Howard County, that they spent a humongous amount for prescriptions for people in the county.

So, middle income people in Howard County can go to the doctor because they can pay for it. They sometimes have a little more money to pay for prescriptions, but the people I deal with in Howard County don't have any way to deal with this. Folks, we're talking about children. We're talking about children with ear infections that need repeated prescriptions, maybe four or five times, need a maintenance dose of a prescription to go on. I just feel that we are a rich country. I could go on and on, but our society has a responsibility to these children. If we let children not be healthy, they grow up behind the eight ball on education, and they don't grow up to be productive adults. I feel that this is why I'm here today, that we have that kind of responsibility.

I'm just going to share with you, we opened this well child clinic in January of this year. Otherwise, there wasn't a lot of services for people with low income. We only accept people that are WIC eligible or Medicaid eligible, so it is a low income clinic. We've seen 300 clients since then unduplicated, and so the nurse practitioner has prescribed 65 prescriptions since we opened. Thirty-three were paid by Medicaid, and 32 were paid for by the clinic. We have local health maintenance funding—whoever is around that can support that for us—that's paying for these prescriptions. They were paid by that funding.

Some of the prescriptions that children had in my records are Ceclor, which for one prescription is \$54, and as I gave you the scenario, you can understand if they can't afford to go to the doctor, they can't afford the prescriptions. Amoxil is another one. Just to be fair, it's \$11. It's cheaper. A lot of children get fungal infections. Nistatin is \$50 a prescription. To treat head lice in children, if we get a prescription through Medicaid, a prescription for that and not over the counter, it's \$45. So, those are the numbers that I have for healthy children.

The information and referral service of the United Way, in 1991, 104 prescriptions were requested by families, children and older adults. Sixty-five percent of these were paid for through local churches. The dollar amount in 1991 was \$574.94 for 104 prescriptions. In 1992, 36 prescriptions were ordered or requested. This again, 63 percent of this was paid for by local churches, and the dollar figure on that was \$664.52. So, in 1991, and I know that prescriptions vary, 104 prescriptions cost \$575. In 1992, 36 prescriptions cost \$665, and I know prescriptions vary as to time, you know, what they cost.

Then, anywhere from 1987 to 1992, the Sutter Township trustees' office, our main trustee in Kokomo, Howard County, spent anywhere from \$9,000 to \$50,000 for prescriptions for people in the county. So, they are the source of the nearly poor prescription health care as far as prescriptions are concerned.

So, I think there needs to be a better system for this, and a better system to take care of our children and take care of our nearly poor people that we don't want to admit are out there, but that I see every day in my practice. Thank you.

Mr. JONTZ. I want to thank all four of the witnesses on this panel for outstanding statements. I don't have any questions for you. I think what you've said speaks for itself, but I do want to recognize Congressman Costello and see if he has any questions at this point.

Mr. COSTELLO. Mr. Chairman, only one question, and it's a difficult question. It would probably take the rest of the afternoon to address, and that is we all know what the problem is and what we're attempting to do here today and what we're attempting to do in Congress is to come up with a solution to the problem. I guess I would ask you, Joe, instead of everyone on the panel, what is the solution to the problem?

Mr. SCIONTI. A cap on drug prices. I don't really understand the bill that is before the Congress right now. My question back to you is what is the consensus as you see it now in the Congress? Does this bill have a chance of getting passed?

Mr. JONTZ. At this time, there is no prospect of legislation passing this year because we're at the end of the 102nd Congress, but I think that health care cost control legislation is very definitely on the agenda for the 103rd Congress, and my belief is that there will be some aspect of that which will address the cost of prescription drugs. One of the ideas is to propose a national health care budget and the cost of all providers, including prescription drugs, would be included in that, and there would be some sort of a rate control mechanism, as you suggest, to put a cap on expense in order to keep the cost within that budget.

I think that Senator Pryor from Arkansas is the one member of the Congress, and he's the chairman of the Senate Committee on Aging, that has probably made—has probably done the most in terms of proposals in this area, but I would expect that anything that is done on prescription drugs would probably be done as a part of some comprehensive health care reform legislation.

So, I think that that has to be a front burner item for the next Congress, and I think my concern and Congressman Costello's concern is that whatever approach we take in this country in terms of national health care reform legislation, it certainly should deal with the cost of prescription drugs, and also deal with the issue of helping people afford those costs. I think it's unconscionable that someone with \$632 of income a month would be paying \$315 of that for prescription drugs. Actually, when you add up all of the medical expenses of Ms. Jamison, you're talking about less than \$100 a month to live on.

Ms. JAMISON. And there has to be fuel bought.

Mr. JONTZ. That's right. So, \$500 out of your \$632 budget goes just for two items, your Blue Cross coverage and your prescription drugs. That's wrong. We've got to, number one, get controls on costs, and number two, we have to help people afford those costs. That's what the purpose of this hearing is, of course, is to get people's input on that, and I think Congressman Costello has the right, you know, is asking the bottom line question, which is how do we go about doing this.

Mr. SCIONTI. You seem to be indicating to us, Congressman, that we're talking about 2 years, 3 years, before something gets done?

Mr. JONTZ. No, I don't know that that is necessarily the case. I think we should pass national health care reform legislation next

hear. It may not all be phased in. It may not all take effect immediately. It may be phased in over some period of time. Clearly, a system to put controls on costs is going to take some time to get phased in, but the sooner we start, the more quickly there will be results, and I think that's why we need to start now.

Mr. SCIONTI. Thank you.

Mr. JONTZ. We want to dismiss this panel and thank you very much for your statements, and call forward the second panel. Let me introduce those panel members as they come forward.

Harry Webb is a pharmacist from the Webb Family Pharmacy in Rochester, Indiana. Joseph Huguenard, Dr. Joseph Huguenard is Vice President for Managed Health Care with the Associated Group in Indianapolis. Jim Verdier is the Assistant Secretary for Medicaid Policy of the Indiana Family and Social Services Administration. Craig Lysinger is a representative of the Indiana Society of Hospital Pharmacists. I would ask them to make any corrections in their titles when they make their statements.

We welcome this panel. You are all individuals with personal experience in providing health care to the citizens of our State, and we want to hear from you what your experience is, and we welcome you, and we'll have you proceed in the order that you were introduced. Please, Mr. Webb, proceed.

STATEMENT OF HARRY R. WEBB, P.D., WEBB FAMILY PHARMACY, ROCHESTER, IN

Mr. WEBB. Well, thank you, Jim and Mr. Costello. I'm really delighted that they asked me to be here today to get a chance to voice a retailer's perspective on the high cost of prescription drugs. As in the previous panel, it's an obvious problem. It's a problem as a retail pharmacist that I see every day. I become frustrated as I see cases that you saw before you. Very common.

As we search for solutions to the nation's health care crisis, this issue of prescription drug prices keeps coming up. As the man mentioned earlier, Mr. Scionti, he said it was on "60 Minutes." The Wall Street Journal just ran an article Friday, and it's going to be an issue for time to come until something is done about it.

In a 10 year period between 1978 and 1988, the Consumer Price Index rose 185 percent in that 10 year period. The cost of pharmaceuticals to the drug store rose 311 percent. That's 125 percent above the Consumer Price Index. The average retail, according to Lilly Digest in the retail drug store rose 252 percent. So, this is an example that retailers are attempting to curb the costs have found ways to become more efficient through computerization. They have cut costs, but still the consumers are bearing the brunt of these increased pharmaceutical costs.

Why do we have increases year after year that are much greater than the Consumer Price Index? I believe it's because manufacturers are allowed to market themselves to select groups at tremendous discounts and then cost shift the price to the average consumer. Many of you may not be aware of this practice, but it happens every day. You hear of health maintenance organizations and hospitals. All of these mail order pharmacies are able to receive

pharmaceuticals at substantial discounts to what a retail pharmacy can buy.

Retail drugs are the one area where the consumer is really trapped. You go to your doctor. He makes a decision as to what drug you should need, what's best going to serve you. You take your prescription to the pharmacy and you have your prescription filled. Approximately 20 to 25 percent of the time, there may be a generic equivalent available that could save you some money, but approximately 80 percent of the time, the drugs the physician is prescribing are not available generically yet. The consumer's only choice in this decision process is if he's going to be compliant or not. His only choice may be I can't afford it, I'm not going to take it. He may take it for a month and decide not to take it, be back in the hospital in another month because of more problems. This escalates the cost of health care to everybody.

Hospitals, health maintenance organizations, and others operate differently. They are able to operate under what is called a formulary or a closed formulary. In a very basic term, what this closed formulary consists of is a committee made up of pharmacists and physicians in the hospital that decide which drugs they are going to use in their facility. What they basically do is take each therapeutic class. They may take drugs that will lower cholesterol, and look at them all on a given meeting. They may decide that three or four drugs are almost identical, but the only different is their cost. They will choose the one drug that is the most cost effective, and that's the drug that will place on their formulary.

Because of the power of these formulary committees, the pharmaceutical companies will approach these formulary committees and offer substantial discounts to be considered. If they're not considered on their formulary, they will submit another bid at a lower price. What happens to those dollars? They become cost shifted to the average consumer. A retail pharmacist like myself, like any chain store, it doesn't matter if it's Phar-Mor or Wal Mart or Walgreen's or an independent, we all basically buy for approximately the same cost, and we are completely locked out of formulary pricing.

One example of formulary pricing using a drug that everybody has heard of and seen advertised thousands of times on television is Tylenol. A hospital in 1985 could buy 1,000 Tylenol tablets for \$2.84. The retail pharmacy at that time could buy them for \$32. I would wager that it's not gone up much from that \$2.84 since 1985, but everybody knows what the price of Tylenol on the shelf is. It's no wonder that you see it advertised as the number one analgesic used in hospitals.

This is an example of what is termed multi-tiered pricing. It's also termed discriminatory pricing. HMO's, hospitals, and mail order pharmacies can participate under this. Anything that's considered a closed group that submits to a select group of people can submit for contract pricing. They have to have a closed group, and a hospital can operate that. It was initially started for non-profit pharmacies and for Veteran's Administration pharmacies and a way to control costs, but has now ballooned to—the Wall Street Journal article from Friday expected that managed care may represent 25 percent of the nation's health care dollars in 1995. All

that managed care and select formularies is going to cause pharmaceutical prices to the general consumer to increase even more to make up for the difference.

In Canada, you've heard probably many times, that they have a national health program. I'm not here today to discuss national health or its pros and cons, but they do have one philosophy as far as drug prices go that is worth a serious look. They have a best price philosophy. If you sell a prescription drug, if you're a prescription drug manufacturer and you want to market your product in Canada, the lowest price you offer any individual in Canada becomes the price for everyone. Everybody is on a level playing field.

In your packet, if you received a handout, there should be a listing that has a comparison of pharmaceuticals, pharmaceutical price comparisons—now, you must realize this is wholesale drug costs, and some of these numbers have probably gone up since these were even printed. It's a comparison of approximately 50 drugs here. I don't know how many is on here, but very common names. I'm sure some of you can recognize them. It shows two very substantial things. One, the price difference between U.S. prices and Canada, in many cases, is very significant, and the price increase that they've seen due to inflation in the last 2 years is much less in Canada than it is in the United States. Because of the one price philosophy, companies are forced to keep their costs down if they want to continue to sell their products.

There have been studies that show that if multitier pricing was banned, it could show up to a 58 percent savings to the consumer. Providing a one price philosophy to all pharmacists would expand the competitive environment that managed care now offers to the retail sector. The Federal Government recognized the great savings that was being missed to Medicaid and Medicare patients when they adopted OBRA-90. They basically created a Medicaid rebate program in which the drug manufacturers had to rebate back to the Federal Government the difference between what their best price was and what the price they were charging a retailer. That amount is now rebated back to the Federal Government for Medicaid and Medicare recipients.

So, legislators are very aware of this cost shifting, and they've recognized it for their own pockets that are our Federal tax dollars that are paying for those programs. Now, isn't it time that consumers have equal access to these same low prices? I urge Mr. Jontz and Mr. Costello to back legislation that would end multi-tier pricing. Thank you very much.

Mr. JONTZ. Thank you for your statement. I do think that I might ask the remaining members of the panel if we can limit the statements to approximately 5 or 6 minutes, if you would. It would be helpful because we may have more questions for this panel than we had for the first panel, and I would appreciate your courtesy in limiting statements to something in that vicinity. Thank you.

**STATEMENT OF JOSEPH HUGUENARD, M.D., VICE PRESIDENT
FOR MANAGED HEALTH CARE, THE ASSOCIATED GROUP, INDI-
ANAPOLIS, IN**

Mr. HUGUENARD. I'll try. I wish to thank the committee on behalf of the Associated Group for the opportunity to give testimony today concerning prescription drug costs from the perspective of the commercial insurer and the health benefit plan administrator.

Prescription drugs are a key part of the effectiveness of modern medical care. Antibiotics, for example, continue to allow cure for diseases that were previously fatal or resulted in serious permanent damage to individuals. Many other prescription medications are able to control diseases and prevent serious side effects, and even death. Anti-hypertensive drugs that are available today are much superior to those that were available 30 years ago, and for most individuals, it means that they will never experience the complications of hypertension if the disease is diagnosed and treated. Many other medications today improve the function and increase the comfort of patients and treatment of both physical and mental illnesses.

Effective prescription drugs not only improve the lives of patients but also in many cases decrease the cost of health care for individuals and for health benefit and insurance plans. The patient that can be treated with medication instead of surgery or other invasive therapy generally has his life improved and quite often experiences less health care costs. Likewise, medications that can cure diseases or prevent significant complications arrest the development of complicating diseases which would otherwise require health care.

Despite this potential for savings or preventing health care costs, prescription drug benefits are a concern. The overall cost of health care continues to rise. The cost of prescription drug benefits is a portion of overall health care benefit cost has also increased. In the 1970's prescription drug costs typically were about 4 percent of an employee health benefit cost in a health plan. In the 1980's, this rose to around 7 percent. In the 1990's, we are estimating the prescription drug costs will be 12 percent of the total health benefit plans for the employee population.

There are many reasons for this increase. Some is due to increased coverage and prescription costs. Other causes include the availability of drugs to treat illnesses for which there were no previous medical therapy, improved and more effective drugs, increased demand for treatment, costs high to over-utilization of medications, and unfortunately, some increased cost is due to the side effects of other prescription drugs so that we actually take some drugs to counter other drugs.

Many benefit plans and health insurers have developed programs to begin addressing costs associated with utilization which does not result in an increased health benefit to the patient. Other program are put in place to encourage the use of generic drugs rather than the brand name drugs when such use can be expected to result in the same benefit to the patient. Other programs have been developed to decrease costs to benefit plans at the retail level

through contracted arrangements with pharmacies and networks of pharmacies.

The experience that Associated Group in Indiana has had with drug costs is that they are increasing faster than the overall health care costs. Prescription drug costs currently represent approximately 8 percent of the total health insurance payment for the Associated Group for Indiana business. Individual account experience does vary significantly as the specific benefits and the characteristics of the coverage group effect the cost. Older populations use more drugs and the benefit, depending on the co-payment, changes the amount of money that's paid out in insurance.

One of our Indiana HMO plans includes programs for address of appropriate utilization of drugs, and it also includes the contract purchase of drugs to control costs at the retail level. This plan, however, has experienced an increase of \$2 per month per member in drug costs between 1991 and 1992. The current cost of prescription drugs in this plan is 14.6 percent of the total health care cost. It may be that high in part because the controls on the rest of the health care have been more effective.

The increase in the last year occurred even though the number of prescriptions per member has not increased. In budgeting for prescription drugs for 1993, we have been advised to anticipate a 10 percent increase in the ingredient costs of the prescriptions. That's the wholesale drug that actually goes to be dispensed. For this HMO, in 1992 there was an increased cost in excess of \$60,000 per month, due only to increased drug prescription costs.

There are many reasons for drug prescription cost increases. Some of these increased costs actually help lower other costs of health care. However, overall health care costs continue to rise while prescription drug costs rise yet faster. Some of these increased costs needs to be dealt with as issues of sufficient drug utilization and costs of acquisition at the retail level. Another significant component appears to be the increasing costs for the drug at the wholesale level of which the health plan administrator and the health insurer have limited understanding, and unfortunately, the limited means to address, and I hope this committee can find some means to address that. I have copies of this for you.

Mr. JONTZ. Thank you. Mr. Verdier?

STATEMENT OF JIM VERDIER, ASSISTANT SECRETARY FOR MEDICAID POLICY, INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

Mr. VERDIER. Thank you, Mr. Chairman. I have a prepared statement which I won't read. I have multiple copies, and I'll just leave it for you. I also have attached to it a copy of the Wall Street Journal article that was mentioned before.

The Medicaid program accounts nationwide for perhaps 12 percent of total spending on prescription drugs, so we are not as large a participant as other purchasers, but I think some of our experience in Indiana may be helpful to you as you think about the larger problem that you're dealing with here today of prescription drug costs in general.

The Indiana Medicaid program per recipient spending on prescription drugs, that is, the amount the State spends for each recipient each year, is the highest in the nation. We're number one. We have been for at least the last 4 years. We've never been lower than fourth during the whole entire decade. We have been puzzling to try to figure out why that is because prescription drug prices are no higher in Indiana than they are in other States. It's essentially a national market.

The reason, as best we can tell, is that the number of prescriptions per recipient in Indiana, at least in the Medicaid program, is substantially higher than in the rest of the country. The rest of the country is about 14 or 15 prescriptions per recipient. Indiana is up around 17 or 19. That may not sound like a lot, but when you're running a program the size of Medicaid, if we could get our average in Indiana in the Medicaid program down to the national average, that would save \$30 million a year out of the \$163 million that we spend on Medicaid in Indiana for prescription drugs.

We don't know why there are more prescriptions per recipient in Indiana than elsewhere. I think that's the experience with private sector payors as well, although we haven't studied it systematically. Some speculation has been that that's what they teach you to do when you go to Indiana University Medical School, and as I say, that's speculation, but it's plausible. It would help to explain it. Another possible explanation is that we have a very unusually high number of elderly people in nursing homes in the Medicaid program in Indiana. Our spending on nursing homes is probably ninth in the nation as a share of our entire Medicaid program. So, that's partially an explanation.

We hope with the establishment of a drug utilization review board in Indiana, which is required by the OBRA-90 legislation that Dr. Webb mentioned, that we'll get some help from them in getting a better understanding of why we seem to be out of line in this dimension in Indiana.

The last point that I would make goes to the point that Dr. Webb made about the so-called restricted formularies that give volume purchasers an opportunity to get lower costs for their programs. This OBRA-90 legislation pretty much eliminated the possibility of Medicaid programs functioning as volume purchasers because we can no longer act as a—we can no longer restrict the number of the type of drugs that we purchase under the Medicaid program. We can't run a restricted formulary and get lower prices as a result of that. What we got in exchange in the OBRA-90 legislation was this best price arrangement that Dr. Webb mentioned that they have in Canada. The problem with that is that yes, as step one, you get the best price everybody else gets, so you get the same—you get the best discount that anybody gets, but what happens is that the drug companies reduce their discounts and raise their prices across the board. Very quickly, that discount that you thought you were getting, that best price that you thought you were getting is eroded, and it disappears.

We got these rebates from manufacturers under the OBRA-90 legislation in Indiana in this last fiscal year. We got about \$20 million, and when that money started coming in the door, I said boy, this is terrific. This is a great deal, but then I looked at how much

our prices had gone up in that year, and they went up \$60 million. So, the price increases in that 1 year just about entirely eroded our rebates, and my guess is that within another year or so, we're still going to be getting the rebates, but the price increases will be in excess of the rebates, and we will not have gotten very much of a deal out of this at all. So, I am a skeptic of these best price arrangements, and I think, from my standpoint, as somebody who is trying to get the best deal for the taxpayers of the State of Indiana who pay for the Medicaid program, I would like to have the ability to run a restricted formulary and not have to rely on these best price rebates which, as I say, I think, are a rapidly eroding benefit.

Thank you very much, Mr. Chairman. I appreciate the opportunity to testify.

[The prepared statement of Jim Verdier follows:]

PRESCRIPTION DRUG COSTS IN THE INDIANA MEDICAID PROGRAM

Statement of
Jim Verdier
Assistant Secretary for Medicaid Policy and Planning
Indiana Family and Social Services Administration

Before the
Subcommittee on Housing and Consumer Interests

of the
House Select Committee on Aging

Logansport, Indiana
September 28, 1992

I appreciate this opportunity to discuss prescription drug costs in the Indiana Medicaid program. While the Medicaid program accounts for only a relatively small portion of total expenditures on prescription drugs -- about 12 percent nationwide -- our experience in Medicaid may give you some insights into the broader issues you are dealing with.

My testimony this afternoon will cover three main points:

- o Indiana's per recipient spending on Medicaid prescription drugs is extremely high, ranking first in the nation for the past four years.
- o The reasons for this high ranking, and therefore what can be done to reduce these high expenditures, are not entirely clear.
- o Federal legislation enacted in 1990 seriously limits the ability of state Medicaid programs to control prescription drug expenditures.

I should make clear at the outset that this testimony represents my personal views, and not necessarily those of the Governor or others in state government.

INDIANA MEDICAID PRESCRIPTION DRUG EXPENDITURES

Indiana ranked first in the nation in per recipient Medicaid spending on prescription drugs in 1990, the most recent year available. Indiana Medicaid spent \$425 per recipient in that year, well above the national average of \$256.

This high ranking is not unusual for Indiana Medicaid. We have ranked first in the nation each year since 1987, and have never ranked lower than fourth since 1981.

Total Medicaid expenditures on prescription drugs in Indiana have grown an average of 20 percent a year since 1984. The rate has grown sharply in the last two years, rising by more than 30 percent in fiscal years 1991 and 1992. Indiana Medicaid spending on prescription drugs reached \$163 million in fiscal year 1992, nearly 8 percent of total Medicaid expenditures.

REASONS FOR INDIANA'S HIGH NATIONAL RANKING

While prescription drug costs in Indiana are high and growing rapidly, this is not what accounts for Indiana's first-in-the-nation ranking in per-recipient Medicaid drug expenditures. Drug prices are set largely in a national marketplace; there is no reason to expect prices to be systematically higher in one state than in another.

Prescriptions Per Recipient

The main reason per recipient spending on prescription drugs is so high in Indiana is that the number of prescriptions per recipient is well above the national average.

State Medicaid programs nationwide average about 14 prescriptions per recipient per year. Indiana's average is well above that -- around 17 to 19 per year. If we could bring the number of prescriptions per recipient down to the national average, we could save over \$30 million a year in the Indiana Medicaid program.

It is far from clear, however, why the number of prescriptions per recipient is so high in Indiana. Some have speculated that Indiana's medical schools emphasize drug treatment options more than medical schools in other states do. Others have suggested that the unusually high number of elderly in nursing homes in Indiana may account for it, since more drugs are normally prescribed for the elderly in nursing homes. (Indiana ranks ninth in the nation in the share of its Medicaid budget spent on nursing home care for the elderly.)

Options For Reducing Medicaid Prescription Drug Expenditures

Since we do not know for sure why Indiana's prescription drug expenditures per recipient are so high, it is difficult to determine at this point what cost containment options are most worth pursuing.

DUR Board. One resource we will shortly have that could help us answer some of these questions is the Drug Utilization Review (DUR) Board that 1990 federal legislation requires each state Medicaid program to establish by January 1993. These Boards -- made up of doctors and pharmacists with special expertise -- will advise Medicaid programs, doctors, and pharmacists about the most cost-effective ways to use prescription drugs. We expect to have Indiana's DUR Board in place soon, and look forward to working with them on this set of questions.

FEDERAL LIMITATIONS ON STATE COST CONTROL OPTIONS

While the 1990 federal legislation (OBRA '90) that authorized DUR Boards took some positive steps to try to bring prescription drug costs under control, the main trade-off in this legislation was not -- in my personal view -- a good deal for state Medicaid programs.

Medicaid Drug Rebates

OBRA '90 required drug manufacturers to extend to state Medicaid programs the "best price" they negotiated with their best volume-purchasing customers. This has resulted in sizable rebates to state Medicaid programs from drug manufacturers. Indiana received approximately \$20 million in drug rebates in state fiscal year 1992.

Prescription drug prices have also grown sharply since 1990, however, as drug manufacturers scaled back the discounts they provided to their best customers and raised prices more generally. Indiana Medicaid expenditures for prescription drugs went up by \$39 million in state fiscal year 1992. About \$16 million of that increase was due to higher drug prices -- nearly as much as the \$20 million we received in drug rebates.

While it may take another year or two for the benefit of these rebates to be entirely eroded by prescription drug price increase, I believe that is the inevitable result of the "best price" approach.

Limitations On State Cost Containment Options

In exchange for these "best price" rebates, the ability of Medicaid programs to control drug costs was limited in a number of ways. Prior authorization has been restricted, as have cost and coverage limitations for new drugs. The most significant restriction, however, is that state Medicaid programs have effectively lost the ability to restrict the types of drugs they cover. Any drug manufacturer who enters into a rebate agreement with a state is entitled to have all its drugs covered under that state's Medicaid program.

Restricted Formularies. As a result, states can no longer use so-called "restricted formularies" to limit Medicaid coverage to the most cost-effective drug if several drugs are available that meet the same medical need. As discussed in more detail in the attached story from last Friday's Wall Street Journal, this ability on the part of drug purchasers and insurers to pick and choose the drugs they cover will, I believe, provide more leverage in the long run for cost containment than the "best price" rebates granted to Medicaid programs in 1990.

State Medicaid programs cannot act like real volume purchasers unless they have the authority to limit the drugs they cover. Medicaid programs have no bargaining leverage with manufacturers if they must cover every drug, no matter how costly and ineffective it is. Medicaid becomes just a bill payer, with the real purchasing decisions being made elsewhere.

OBRA '90 took away our ability to act as volume purchasers, and in exchange let us piggyback on the discounts received by real volume purchasers through the "best price" rebate system. This system is, in my judgement, unstable and unreliable both economically and politically. Drug manufacturers can increase prices to offset the amount of the rebates; this has happened already. In addition, volume purchasers with significant political influence -- such as the Veterans Administration and hospitals serving large numbers of low-income people -- can and will gain exemption from the "best price" calculations. Discounts to them will not count. Both effects will ultimately erode the ostensible benefits of the "best price" rebates.

State Medicaid programs would be better off, in my judgement, with a strengthened ability to restrict the drugs they cover to those that are most cost-effective and medically necessary.

CONCLUSION

Again, I appreciate your invitation to testify, and I would be happy to answer any questions you may have.

Buyer's Market

Prescribing Decisions Increasingly Are Made By the Cost-Conscious

Doctors Are Pressured to Bow To Votes of Committees And Their Formularies

Effect on Drug Firms' Profits

By RON WINSLOW

Staff Reporter of THE WALL STREET JOURNAL

MINNEAPOLIS—A dozen doctors meeting here are deciding what drugs their patients should take, but they aren't writing prescriptions. They are taking a vote.

In a showdown between some of the pharmaceutical industry's hottest new drugs, the doctors are considering whether to approve a cholesterol treatment from Bristol-Myers Squibb Co. or a nearly identical one from Merck & Co. Should they adopt a new antidepressant made by Pfizer or stick with Eli Lilly & Co.'s Prozac? An antibiotic from Pfizer is among other remedies on the agenda.

Drugs they say yes to will be added to a master list for Medica, a local health plan that spends \$47 million a year on prescriptions. Those that are denied won't be prescribed for the plan's 545,000 members. In voting, the doctors weigh the cost-effectiveness of the drugs.

The list is called a formulary. In the war on U.S. health costs, it is the Patriot missile aimed at the pharmaceutical industry. For the first time, drug purchasers have an antidote to the industry's vaunted marketing power in the \$67 billion-a-year U.S. prescription-drug market. They aren't just saving money, they are changing the face and fortune of one of the world's most profitable industries.

Committee Decisions

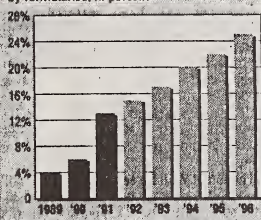
"By the year 2000, most pharmacy purchases will be made by committees rather than by individual physicians prescribing for patients," says Alan L. Hillman of the University of Pennsylvania's Leonard Davis Institute in Philadelphia.

Indeed, health maintenance organizations, pharmacy management companies and their corporate clients are already transforming prescribing practices of U.S. doctors and pharmacists with formularies and related "managed care" techniques. They are negotiating discounts and requiring use of cheaper generic drugs over brand-name products. And they are backing their efforts with state-of-the-art computer technology that can check instantly each prescription against the formulary at the point of sale and gather data on the performance of both individual doctors and the entire health plan.

"I can tell you today what drug any doctor in any of our plans around the country prescribed yesterday," says An-

Managing Drug Costs

Number of outpatient prescriptions covered by formularies, in percent



Note: Figures from 1992 to 1996 are estimates.
Source: Sanford C. Bernstein & Co.

thony Zappa, senior manager of clinical programs at Diversified Pharmaceutical Services in Minneapolis. That is no idle boast. The United HealthCare Corp. unit manages drug programs for 86 health plans with about 100,000 participating doctors writing \$333 million in prescriptions a year for more than six million patients.

Looking Askance at Profits

The emergence of an aggressive buyer's market coincides with increasing attacks in Congress on robust pharmaceutical industry profits and widespread concern over rising health costs. These forces are curbing the ability of companies to command prices in the U.S. — the industry's most important market. And the impact is beginning to show up where it counts: Annual industry profit growth could dip to as low as 11% this year, analysts say, after years of steady growth in the high teens.

The current doldrums reflect the pledge of many companies to hold 1992 price increases to the rate of inflation in the face of political pressure. But some experts maintain that formularies and other market forces pose a bigger long-term threat to the industry than government action. Kenneth S. Abramowitz, analyst at Sanford C. Bernstein & Co., predicts that by 1996 prescriptions covered by formularies will double to 25%, while drug benefits of nearly three-quarters of the U.S. work force will be subject to some kind of cost management, up from about 40% currently.

In response, the world's drug makers are engaged in a frenzied quest for a diverse, leading-edge portfolio of drugs needed to prosper — or even to just survive — in the global marketplace. Even the strongest companies are recasting themselves — by revamping sales and research and in a flurry of mergers, investments and marketing alliances.

"Managed care is reshaping the industry," says Richard Markham, senior vice president at Merck. "Companies that don't

Please Turn to Page A6, Column 1

Buyer's Market: More Prescribing Decisions Now Are Based on Cost-Effectiveness of Available Drugs

Continued From First Page

have produced research organizations that can bring innovative medicines to the market will get left behind."

In the most telling reflection of the new era, Merck, the world's leading drug maker, stunned the industry last winter when Chairman P. Roy Vagelos announced the company would trim its 2,200-person U.S. sales force through attrition—normally about 8% a year. Dr. Vagelos cited, among other reasons, expectations that managed-care contracts would account for two-thirds of U.S. sales by 1995, a sixfold increase over 10 years ago. Other companies have yet to follow suit, but nearly all have established special units to sell to the managed-care market.

SmithKline Beecham PLC said early this month it will halt internal basic research for new ulcer drugs, long one of its major therapeutic areas, even though its Tagamet remedy is the second-leading seller in a \$5 billion world-wide market. The decision, says analyst Hemant K. Shah, of HKS & Co., in Warren, N.J., recognizes that from now on, new drugs will fail commercially if they offer only marginal benefits over existing treatments, especially considering that low-priced generic versions of products like Tagamet will be on the market soon.

Major drug companies are wooing biotechnology, an industry with more than 100 new products in final stages of U.S. regulatory review and hundreds of other tantalizing prospects under development. Schering-Plough Corp., Roche Holding AG, American Home Products Corp., Sandoz Ltd., Chugai Pharmaceutical Co., SmithKline, and Lilly are among drug makers that have acquired stakes in biotechnology concerns in the past three years.

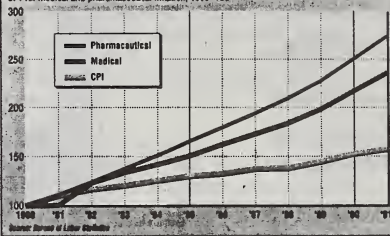
At the same time, marketing alliances and licensing pacts are proliferating like viruses, often linking archrivals in the scramble to diversify product lines. Under a Merck-SmithKline alliance announced late last year, for instance, SmithKline is co-marketing Zocor, Merck's new anti-cholesterol drug, in the U.S. What Merck co-market hasn't been determined, but one candidate, analysts say, is Serenax, an antidepressant awaiting U.S. marketing approval that SmithKline licensed from Novo Nordisk AS, a Danish drug maker. In managed-care negotiations, companies with a diverse offering of drugs can bundle some of them in package deals to get more of their products on formularies.

One reason the industry is vulnerable to a buyer's market is a glut of redundant medicines. A list of the 100 top-selling drugs by 1991 world-wide sales compiled by Medical Advertising News includes six ulcer treatments; four ACE inhibitors and seven calcium channel blockers, all for high blood pressure; four cholesterol-lowering drugs (with a fifth launched at the end of 1991); five arthritis remedies; and 22 antibiotics.

Drug company sales representatives, known as detailers, argue that their products offer unique clinical benefits, but managed-care strategists maintain that differences between drugs in the same class are often negligible. They are urging

Prescription Drug Prices Outpace Medical Prices

CPI vs. medical and pharmaceutical inflation, 1960-1990



doctors to prescribe cheaper drugs first. And they are extracting price cuts from drug makers in exchange for market share. "The message to the pharmaceutical industry is that getting your drug on the formulary will require a discount," says Henry P. Blissenbach, president of Diversified Pharmaceutical Services.

Shape of Things to Come

All of this portends a future much different from the seller's market drug companies have had for many years. Their skilled detailers have been the primary source of drug information for the nation's 550,000 doctors. Most of the \$50 billion of drugstore prescriptions purchased yearly are sold in millions of individual transactions between doctors, patients and pharmacists—one bottle of pills at a time.

Such feeble purchasing power is one reason drug prices have soared at three times the inflation rate since 1968. It also helps explain why the industry's marketing machine has been so successful at persuading doctors to prescribe expensive brand-name drugs as first-line therapy when cheaper or generic versions would probably do just as well.

These factors have helped make prescription drugs, which account for 10% of employer-paid health benefits, a prime target in the health-cost battle. With formularies and other strategies, employers and their health plans are acquiring the volume buying power to counter the industry's marketing clout.

Without a formula, the company that details best wins the ball game," says Robert Hovda, who heads the committee that decides which drugs doctors in Medicine, the Minneapolis HMO, will prescribe. "With a formulary, you have to have a good drug."

Regulating Generics

A particularly potent formulary-based strategy requires doctors to prescribe available generic versions of brand-name drugs. In HMOs, which routinely use such generic substitution, 40% of all prescriptions are for generics, compared with 20% to 25% outside of HMOs.

McKesson Corp.'s PCS unit plans to use

generic substitution and a discount-pharmacy network to save the federal government more than \$100 million a year under a new contract covering 3.1 million federal employees, retirees and dependents. "One decision-maker, instead of more than 1,000 doctors, will affect the purchase of 20 million prescriptions," says Elizabeth Dichter, vice president of marketing.

Value Health Inc.'s ValueRx unit and Medco Containment Services Inc. use social counter-detailing to educate doctors and offset drug company pitches. ValueRx found, for instance, that 1,500 doctors in New York state typically prescribe a brand-name arthritis remedy instead of trying prescription-strength ibuprofen—at one-tenth the cost. "For the majority of patients, ibuprofen would be the best first choice," says Jonathan Edelson, senior vice president. Through intensive physician education, ValueRx expects to cut use of brand-name medicines among the doctors by at least 25%.

At Diversified Pharmaceutical Services, a staff of pharmacists begins tracking new drugs through medical and trade journals and other sources at least six months before they are expected to reach the market. By the time drug company representatives knock on their door, the pharmacists are well-acquainted with the products and how they match up against competitors.

Committee Oversight

The pharmacists prepare reports to physician panels called pharmacy and therapeutic committees that oversee formularies for individual health plans. Recent meetings of such committees for Medicine, which is owned by United Health Care, and Empire Blue Cross and Blue Shield in New York City, offer an inside look at the process.

Meeting agendas are set out in blue booklets that devote a page or two to describe indications, side effects, dosage and uses for each drug up for consideration. The booklets also reflect any volume-purchase contracts Diversified Pharmaceutical Services negotiates with drug makers and, in the style of restaurant guides, rank a product's cost to the health

plan on a scale from \$ to \$5555.

When Merck's Zocor (pravastatin) 15555—two cholesterol-lowering drugs—came up for discussion at Empire, Mr. Zappa says: "I don't think we'd be sacrificing anything clinically to have [Pravachol] as the preferred drug."

The 20% price difference reflects a discount not only for Pravachol, but for Monopril and Capoten, two blood pressure medicines that Bristol-Myers bundled in a package deal. "They significantly dropped the price on Capoten," Mr. Blissenbach tells the committee. "Pravachol essentially brought them to the table." The Empire committee goes along with DPS's recommendation to adopt Pravachol and leaves Zocor off the formulary.

But in a similar discussion at the Medica plan, Kevin Graham, the cardiologist on the committee, objects. He had worked with Zocor in clinical trials and was impressed with the results. "It's potent, and it's long-acting" at lower doses than its competitors, Dr. Graham says.

Bowing to Medical Expertise

"It's a competitive marketplace, and we're trying to get the industry to lower its prices," Mr. Zappa replies. But the other doctors on the committee bow to their colleague's preference and add both drugs to the formulary.

Both committees go along with a recommendation to use Ziltroxam, despite the fact that despite the company's position that it doesn't linger in the body as long as Lilly's Prozac and may thus result in less insomnia, anxiety, and other side effects. "The data aren't as clear as Pfizer likes to think they are," Mr. Zappa says. But he and Mr. Blissenbach also worry that a second drug will increase the market.

A third antidepressant, SmithKline's Serenax, is expected to hit the market soon, and they're trying to review the entire category when it does. "Serenax appears to be as good as, if not better than [the others]," Mr. Blissenbach says, "and it will be cheaper."

The committees also reject a Pfizer antibiotic called Zithromax, despite unanimous agreement that it is a cut above others. The reason: It costs nearly \$8 a pill, wholesale. "If they had come in at half that price, they would have cleared house," says Medica's Dr. Hovda.

Price and Value

Drug companies maintain that price competition alone isn't the measure of their products, and some are reshaping marketing efforts to demonstrate that their medicines add value to a health plan's overall program. Merck argues, for instance, that its Vasotec blood pressure medicine recently approved by the FDA for congestive heart failure can save tens of thousands of dollars per patient in hospital and other costs. Pfizer says patients don't need to take as much Ziltroxam to cure a condition as they do other antibiotics. That should increase patients' compliance in taking their medicine, the company says.

"It's the cost per capsule [of Ziltroxam] that scared those physicians," says one Pfizer official. "But for a number of other drugs, the total course of therapy may cost more. These committees meet over and over again, and we will keep plugging away."

Meantime, committee decisions will have minimal impact unless the hundreds of doctors in each plan abide by them in treating their patients. DPS uses newsletters and other devices to inform physicians about the formulary and the rationale behind the committee's actions. Doctors who persistently prescribe contrary to the formulary are often asked to explain their decisions. The blue agenda book also includes a quarterly report on each off-formulary drug prescribed.

Another enforcement step is the drugstore itself. At Fairview Community Pharmacy in Edina, Minn., the fingerprints of drug company representatives are everywhere in sight. In the form of coffee mugs, note pads and pens advertising new products. But the most influential item in the store is the computer.

When Bob Beachler, the pharmacist there, enters a prescription for Proventil, an asthma treatment, for a Medica member, the computer relays within 15 seconds the information that the drug isn't on the formulary. That prompts a call to the doctor to see whether Ventolin, which is on the list, can be dispensed instead.

"We have detail people in our office every noon, five days a week," says Dr. Hovda. "If they don't have their medicines on formulary, they're almost dead in the water."

PHARMACEUTICAL PRICE COMPARISON CANADA vs the UNITED STATES

This table shows the net prices (expressed in U.S. dollars) at which pharmaceutical manufacturers sold their NAME-BRAND drugs (directly or through wholesalers) to retail pharmacies in the United States and Canada in May of 1990 and May of 1992. Columns eight and nine show the rate of the price increase for the product in each country (or in some cases in Canada, price decreases). In a like period the general inflation rate in the U.S. was 8.3% and in Canada 6.6%.

MEDICATION	MANUFACTURER	USE	U.S. PRICES		CANADIAN PRICES		PRICE INCREASE	
			1990	1992	1990	1992	U.S.	CANADA
Nitrostat 0.3 mg tabs	Parke Davis	Heart	2.88	4.34	2.17	2.17	50.7%	0.0%
Dilantin 100 mg caps	Parke Davis	Epilepsy	11.29	16.83	5.08	5.28	49.1%	3.9%
Azmacort Inhaler (20gm)	Rhone-Poulenc	Asthma	20.64	30.20	12.32	13.60	46.3%	10.3%
Entex LA tabs	P&G Pharm.	Congestion	38.25	53.13	23.20	25.58	38.9%	10.2%
Tagamet 300 mg tabs	SmithKline B.	Ulcers	51.88	70.11	29.05	34.73	35.1%	19.5%
Tobrex eye drops (5 ml)	Alcon	Antibiotic	9.25	12.40	6.62	7.35	34.0%	11.0%
Orudis 50 mg caps	Wyeth-Ayerst	Arthritis	56.92	75.87	27.52	28.29	33.3%	6.4%
Anusol HC supp (12)	Parke Davis	Hemorrhoids	12.12	16.13	7.52	8.21	33.1%	9.1%
Coumadin 5 mg tabs	Dupont	Blood Thinner	34.45	45.36	18.12	24.42	31.6%	34.7%
Capoten 25 mg tabs	Squibb	Blood Pressure	39.00	50.37	40.24	46.28	29.1%	15.0%
Nizoral 200 mg tabs	Janssen	Antifungal	162.28	209.04	146.03	155.68	28.8%	9.3%
Inderal 20mg tabs	Wyeth-Ayerst	Blood Pressure	22.51	28.79	13.79	15.20	27.9%	10.2%
Estrace 1 mg tabs	Mead Johnson	Estrogen	18.99	24.28	14.90	16.53	27.8%	16.5%
Duricef 500 mg caps	Mead Johnson	Antibiotic	189.38	241.87	93.62	103.82	27.7%	10.9%
Macroclantin 50 mg caps	P&G Pharm.	Antibiotic	42.45	53.64	27.03	28.94	25.9%	7.0%
Persantine 25 mg tabs	Boehringer I.	Heart	19.74	24.75	20.99	23.06	25.4%	9.8%
Catapres 0.2 mg tabs	Boehringer I.	Blood Pressure	50.96	63.87	38.37	42.15	25.3%	9.8%
Beconase A-Q spray (25gm)	AllenHansbury	Allergy	20.58	25.75	13.62	15.15	25.2%	11.2%
d 150 mg caps (60)	Lilly	Ulcers	57.80	71.78	36.24	41.55	24.2%	14.6%
synthroid 0.1 mg tabs	Boots	Thyroid	13.50	16.74	4.25	4.67	24.0%	9.8%
Ativan 1 mg tabs	Wyeth-Ayerst	Tranquillizer	41.61	51.60	7.90	7.90	24.0%	0.0%
Ventolin Inhaler (17gm)	AllenHansbury	Asthma	14.77	18.31	9.54	10.63	23.9%	11.4%
Zovirax 200 mg caps	B. Wellcome	Shingles/Herpes	60.38	74.63	86.70	95.79	23.6%	10.4%
Cipro 500 mg tabs (50)	Miles	Antibiotic	102.97	127.01	93.50	106.49	23.3%	14.4%
Prozac 20 mg caps	Dista	Depression	141.15	173.68	121.57	137.22	23.1%	13.2%
Ceclor 250 mg caps	Lilly	Antibiotic	134.17	164.90	79.37	87.90	22.9%	10.7%
Keflex 500 mg	Dista	Antibiotic	168.77	207.41	54.47	68.42	22.8%	25.6%
Feldene 20 mg caps	Pfizer	Arthritis	156.96	192.58	106.05	129.26	22.7%	13.3%
Premarin 0.625 mg tabs	Wyeth-Ayerst	Estrogen	22.53	27.63	11.41	14.50	22.6%	27.0%
Nicorette 2 mg (96)	M. M. Dow	Smoking Cessat.	24.84	30.24	19.28	21.40	21.7%	10.9%
Seldane 60 mg tabs	M. M. Dow	Antihistamine	61.02	73.65	36.17	35.06	20.7%	-3.0%
Hismanal tabs	Janssen	Antihistamine	119.03	143.28	69.02	64.21	20.4%	-6.9%
Floralinal tabs	Sandoz	Pain Relief	29.10	34.99	16.78	20.18	20.2%	20.2%
Cardizem 60 mg tabs	M. M. Dow	Heart / BP	44.82	53.83	48.96	55.38	20.1%	13.1%
Sinemet 25/100 tabs	Dupont	Parkinsons	44.82	53.82	41.33	46.45	20.0%	12.1%
Reglan 10 mg tabs	Robins	G-I "control"	31.50	37.70	13.24	17.42	19.7%	31.5%
Xanax 0.5 mg tabs	Upjohn	Tranquillizer	43.50	51.92	16.70	17.17	19.3%	2.8%
Halcion 0.25 mg tabs	Upjohn	Tranquillizer	43.39	51.74	15.81	17.21	19.2%	8.8%
Atrovent spray (14 gm)	Boehringer I.	Asthma	17.70	21.03	12.23	13.43	18.8%	9.8%
Provera 10 mg tabs	Upjohn	Hormone	41.07	48.75	39.22	42.79	18.7%	9.1%
Tenormin 50 mg tabs	ICI Pharm	Blood Pressure	61.12	72.18	44.14	49.27	18.1%	11.6%
Tavist-D tabs	Sandoz	Antihistamine	60.75	71.55	34.64	34.70	17.7%	0.0%
Theo-Dur 300 mg tabs	Key	Asthma	20.19	23.69	21.59	22.61	17.3%	4.7%
Lopressor 50 mg tabs	Geigy	Blood Pressure	35.38	41.45	18.44	20.04	17.1%	10.8%
Voltaren 50 mg tabs	Geigy	Arthritis	64.10	75.11	51.13	55.56	17.1%	8.6%
Low-K 6 meq tabs	Summit	Potassium supp.	11.57	13.42	7.53	7.20	16.1%	-4.3%
id 60 meq tabs (60)	Parke Davis	Cholesterol	39.35	45.22	39.70	43.77	14.9%	10.2%
Ansaid 100 mg tabs	Upjohn	Arthritis	77.27	87.99	48.74	52.70	13.8%	8.1%
Lanoxin 0.125 mg tabs	B. Wellcome	Heart	7.76	8.83	6.97	7.65	13.8%	9.7%
Zantac 150 mg tabs	Glaxo	Ulcers	118.18	132.66	83.64	93.10	12.2%	11.3%

All prices are for quantities of 100 tablets or capsules except where otherwise shown in ()

PHARMACEUTICAL PRICE COMPARISON CANADA vs the UNITED STATES MAY 1990 AND MAY 1992

Mr. JONTZ. Thank you, Mr. Verdier. Mr. Lysinger, if you have a title with the Society of Hospital Pharmacists, I would appreciate it if you would provide it for the record at this point.

STATEMENT OF CRAIG LYSINGER, INDIANA SOCIETY OF HOSPITAL PHARMACISTS

Mr. LYSINGER. Thank you, Mr. Chairman. My capacity with the Indiana Society of Hospital Pharmacists is just as a member. I am a former board member of that organization and currently just serve as a member. I appreciate the opportunity to be able to express to you and those others present today some perspectives from the institutional pharmacy practice in the State of Indiana.

As we look at the various issues that drive up the cost of pharmaceuticals in our business, we also recognize that at least in the short term, pharmaceuticals have been driving the cost of health care up proportionately more than any other component within the mix, and we have noted as a group significant increases in the 85 to 89 time period. I believe the Propac figures indicate significant increases.

Hospital pharmacists have for many years been involved, and very actively involved, in a variety of mechanisms to try to control the cost of pharmaceuticals that are provided in the care of patients in the hospital. Dr. Webb mentioned some of the issues related to formularies, closed formularies, restricted formularies. There are therapeutic interchange activities in some areas of the country where basically therapeutic substitutions are provided by virtue of a PNT committee, pharmaceutical therapeutics committee, to provide alternatives to look at cost effective products. So, hospital pharmacists continue to provide those kinds of services, and would look forward to providing those kinds of controls in the future.

One of the things that I want to caution the committee as they look at controls or various ways to control the cost is that at least from the experience of hospital pharmacy, in recent years, the last couple of years in particular, since the prior legislation, hospital pharmacies, and hospital pharmacists have experienced tremendous increases in the price of products, to the best of my knowledge, without compensatory reductions in the retail sector. So, as the best price scenario has been afforded the Medicaid providers and other kinds of providers have negotiated maximum costs, we have seen tremendous increases. I believe the American Society of Hospital Pharmacists have done some studies which indicate something like 15 percent and 35 percent respectively the increases during the course of the last 2 years.

Within Indiana, we've experienced it as well. A member hospital of the society did a brief study this weekend to try to analyze some of the cost factors that they've experienced since that particular legislation. One of the things that they've noted is that even with products that are not the new technology, new release type products, more traditional products that are commonly used, they have experienced something like 61 percent increase over the course of the last 2 years as it relates to their price release products.

So, I want to caution the committee as it relates to looking at controlling the cost of providing in essence a discount or a best

price scenario in one sector of the market. What happens in the other sector of the market, we've just chased the price. Perhaps it is cost shifting back into the institutional setting without a compensatory reduction in the retail setting.

Another thing that I'm aware that's being considered at least has to do with the elimination of discounts for non-profits that I think were set in place by the Non-Profit Institutions Act of 1938. There have been a number of studies performed to analyze what impact that might have on the institutional pharmacy expenditures over the course of a year. The estimates I've read would account to about a 23.4 percent increase, would result in the elimination of the non-profit discounts or price preferentials that are provided to non-profit institutions throughout the country.

So again, as you look at options, if that goes away without the compensatory reduction in other sectors of the market, we're just pushing the dollar from one sector of the health care arena to the other.

Hospital pharmacists are very concerned about the advent of the biotech pharmaceuticals that are coming on the market, some approved, some soon to be approved, and what kind of an impact that may have on individual pharmacy budgets which create costs that are passed along to the consumers. Some projections indicate that the drugs could add a half to a million dollars to the average pharmacy expenditures during the course of a year, which will then be passed along to the consumers in cost increase or additional costs for the care.

While it's certain that some efficiencies will be gained by new biotech pharmaceuticals that perhaps will reduce other health care costs, whether in fact there will be compensatory reductions, I believe as a previous speaker mentioned, is questionable at this point in time.

So, to summarize, I guess, the Indiana Society's position or recommendations to you as you go back to look at various solutions, the recommendation of the Society is that perhaps that you would consider supporting the legislation that's been introduced by Slatery and Chafey that would basically put—eliminate the best price and put a flat discount on the price that the preferred provider, particularly Medicaid, would be getting off of an average or a market price, manufacturer's price, rather than the best price scenario. This would provide Medicaid with their market driven price advantage or obtaining a negotiated discount, which perhaps might serve Mr. Verdier's needs, but by the same token—he doesn't think so. But by the same token, that you please not consider eliminating the not for profit pricing for pharmaceuticals to non-profit institutions without analyzing the compensatory costs shift will result into the hospital market.

Mr. JONTZ. I want to thank all of this panel. I think it's interested to hear the dialogue back and forth about how you approach this problem, and I guess I have to ask this question after this discussion, and I'll start with you, Mr. Lysinger. Is there any alternative to just dealing with costs across the board, in putting a cap across the board? Are we really going to solve this problem if we just go back and forth between allowing this group to have a discount and allowing that group to have a discount. Is there any al-

ternative to putting across the board—at least across the board review of costs and capping and putting some sort of a system of caps in place where that's determined to be justified?

Mr. LYSINGER. I guess the society, speaking on behalf of myself, this month's Society has not taken a position on this issue, to the best of my knowledge, but I guess my perspective is that the control issue or regulation has rarely, at least in my experience, has rarely resulted in the end point one seeks, particularly when we have a semblance of a free market kind of a system. What we've had now is basically the ability of various components of the market to cost shift into the other components as the number of uninsured or the population is then, in fact, is paying for their care. They're being cost shifted, and that population is growing, and eventually there will be a market shift back. I'm skeptical of fixing the issue with just legislation or regulation.

Mr. JONTZ. Well, help me, then, in understanding how we can make the market work better. Mr. Verdier, you touched on a sensitive little point there, which is how medical doctors are trained. I'm not sure I'm quoting the figure correctly, but if my numbers are correct, pharmaceutical manufacturers in this country spend an average of \$3,000 per physician to market drugs. Now, as I understand the way this system works, the pharmaceutical manufacturers understand that M.D.'s write prescriptions, and so they heavily focus their marketing and promotional programs on specific physicians, and I'm sure that that \$3,000 average masks the fact that probably some get taken to very few steak dinners and more probably some get taken to more, based on where they are in terms of their ability to prescribe.

The pharmaceutical manufacturers obviously market specific brand names or promote specific brand names very heavily, and you have a system, in part, because of the fact that M.D.'s are expected to know so much, where what M.D.'s know about drug products often is based, or influenced perhaps, to a great degree than it should be, on the promotional efforts of specific pharmaceutical manufacturers to promote specific drugs. It seems to me that this is a characteristic of our system that we have to come to grips with because if this is the way it works, there is no market system out there in the sense of real price competition. This promotion goes beyond just giving doctors tablets of little writing paper that we have the name of the drug on. There are significant investments there.

I guess my question is how do we deal with that? This is a question for anyone on the panel. How do we introduce price competition when what's it to the doctor? If the insurance company is covering it and they are influenced to promote specific brands or prescribe specific brands—of course, that's why we have a generic drug law, but that doesn't always work. Would anyone like to tackle that question?

Mr. VERDIER. Mr. Chairman, I think you put your finger on an important part of the problem, that people who are deciding what drugs to prescribe don't pay anything for those drugs, and indeed, they may benefit by prescribing more expensive drugs. At a minimum, they're trained in medical school to prescribe the best, most medically effective drug, and they're not taught an awful lot about

how much these drugs cost and whether there might be therapeutically equivalent drugs that would cost a half or a quarter as much.

What you need to do is set up a system where there are knowledgeable purchasers who do, in fact, bear the cost, that evaluate the kinds of drugs that are coming onto the market from the drug companies. Those knowledgeable purchasers are, number one, insurance companies. They've got the expertise to do the research. They're the ones who pay the cost initially, and hospitals. They also have the expertise. They pay the cost. Medicaid programs have the expertise. They pay the cost. What you have to do is to have knowledgeable purchasers who are the ones who bear the cost.

I think a lot of the people in this room, if they're not fully insured, end up paying the costs as well, and if we could do something in the way of consumer education by providing a list of therapeutically equivalent drugs, including some generic drugs, and say take this list to your doctor and ask them whether there is any reason why the lower priced drug shouldn't be prescribed because if the patient is paying for a significant portion of that cost, then that's something that they have a right to know about.

Mr. HUGUENARD. I agree with that generally. I think there's some more specific things we could touch on. We heard mention of formularies before, and formularies are basically lists of drugs that are available, either in a hospital or through a health plan, particularly an HMO. We heard mention of the formulary as a way of getting contracted lower prices. There is another very important aspect, and sometimes a much more important aspect, and that is precisely what you're referring to, is by having committees of physicians and pharmacists look at the therapeutic equivalent of drugs and placing on the formulary the most cost effective drug, that is the drug that is standardly available, and aside from any contracting savings that you might have, there are very significant savings in using the most cost effective drug in a class of drugs that has the same effect as the first drug.

If that doesn't work for a patient, most formularies let you opt out to another one, but it certainly makes sense to start with that, and that's something that I think we need to have laws that allow that to continue. I think that we've heard that Medicaid at this time doesn't have that capacity. I think that probably straps them because it isn't just that they have to offer all drugs and therefore don't get contract discounts. They have to offer all drugs, even those that they do not feel are as effective as others. Insurers also grapple with that.

Mr. WEBB. If I might make a comment. First, I do want to point out a typo on my card. I am not a doctor. I'm a mister. Mr. Webb is fine.

Just to throw a little more comment into it, you know, the average physician, when I was taught in school, and I see it in the marketplace. It's probably very true. The average physician prescribes generally between 20 and 30 drugs on a routine basis. You know, there are hundreds and hundreds and thousands of drugs on the market, but that one physician tends to use probably 20 drugs 90 percent of the time. No matter what you go in the office for, he's going to probably pull from that little bag of tricks. Those 20 are

obviously very much influenced by what drugs the hospital has on their formulary.

If they have a formulary in place and they're recommending a certain drug, and he's asking to use it in the hospital, chances are he's going to have to use it in his own practice once he releases the patients from the hospital or whatever. That is how—as long as you look at a managed care approach as trying to control costs, it's going to benefit a good portion of the people, but it's never going to benefit everybody unless everybody is under the same managed care proposal. Then you're saying that we're only going to have one drug out for diabetes and one drug out for cholesterol treatment? I don't think the drug companies are going to allow that kind of legislation to take place.

If it's a one price for everybody, regardless if they're in a managed care situation or in a private pay Joe Citizens that has no insurance whatsoever, then those formularies are still going to have effects because they're still evaluating for lowest costs. They're still going to be—it may have cost shifted up. They may not be paying \$20 or a penny apiece for the nitroglycerine packages anymore. They may have to pay \$1.50 like the rest of us, but the formulary committees are still going to be looking for lowest cost to put that drug on the market, and eventually, the drug companies are going to be forced to be more and more price competitive.

I don't think we've seen the real benefit of the Medicaid rebate program at that point. A pharmaceutical manufacturer, once they know they had a rebate back to the Federal Government all these dollars, their first reaction was to raise their prices. That is natural. They're not going to wait until after the fact to find out that they really are going to owe a lot of money. Their first reaction is to raise their low prices they're offering and let the storm weather, and then they're going to realize where they can be competitive, and they're going to start lowering prices.

The drug companies have already in the last year dramatically curbed their increases. They're now seeing something more around the consumer price index. Some companies have made big public statements about how they're going to follow the consumer price index and stay right at 4 percent. I don't know where these drug companies were 3 or 4 years ago, but they weren't saying that then, and I think they are allowed to say those statements because they are still being able to remain profitable, and I think everybody wants our drug industry to stay profitable. Nobody wants to sit there and make these guys stop research and stop development, but if everybody is on a level playing field, then everybody is going to benefit. You're not going to have one group benefiting, and another group cost shifting that.

Mr. JONTZ. Let me ask Congressman Costello at this point if he has questions for the panel.

Mr. COSTELLO. Just a brief question for Mr. Webb. Actually two, very quickly. One is that I couldn't help but notice that when Mr. Lysinger asked us to take a look at the Slaterry Bill, you were shaking your head no. Do you want to comment about that?

Mr. WEBB. That is a flat rebate to the manufacturer. It just would completely eliminate the whole point of ending multi-tier pricing. If you're just—it's just going to get right back into it again.

Naturally, the entities that benefit most from that are the hospitals and the HMO's because then they can go back and re-negotiate their real low prices again, and Medicaid is going to get their 15 of 20 percent off wholesale price rebate, but it isn't going—and it may look like initially it would be more to them, but if they want the best price, I think the legislation should stand as originally intended.

Mr. COSTELLO. The other issue, for the benefit of those who are in the audience here, is I recently met with a group of pharmacists in my Congressional District, and I was surprised to learn that the very small margin of profit that the family pharmacy gets today, and I wonder if you might talk just for a moment about that very quickly, without going into great detail.

Mr. WEBB. Well, I'd say most retail pharmacies, because of the competitive nature of, you know, anybody that's been around long enough in the last 20 years has realized that the pharmacy has dramatically changed. The old independent retail pharmacies, a lot of them have closed, and big chain outfits have come in and have generated an awful lot of image on price, and that has forced everybody to be more competitive. I don't think there's anybody out there making a killing. It's a very, you know, I'd say the average gross margin is, you know, in the range of 20 to 30 percent, and that's probably standard for any retail business. Of course, on the very expensive pharmaceuticals, it's a lot less than that.

Mr. COSTELLO. Thank you, Mr. Chairman.

Mr. JONTZ. I don't have any further questions, I guess, from this panel, but it seems to me that one of the things we have to do to have effective health care cost containment is to make better utilization of various health care professionals who have skills and experience that can be focused on specific aspects of health care costs, and surely, part of what we have to do is find a way to utilize the talents and experience and education of pharmacists to be making decisions about drug products, which is what you are educated to do. There's obviously some disagreement on this panel about just how to do that, but we need to utilize that ability, and that's what we're going to be searching for in terms of looking at this overall problem.

Let me thank you again for your statements and dismiss this panel. I call forward our next panel. I think everyone has the agenda. The next panel, we have two representatives of senior citizens' organizations, and they will be followed by representatives of Eli Lilly and Company. So, we have some very important witnesses yet to hear.

First of all, Paul Severance is the Director of United Senior Action. His home is in Indianapolis, and then Bob Lancaster is the Representative today of the American Association of Retired Persons. His home is in Rochester. We welcome you two, and we'll hear your statements at this point. Please proceed, Mr. Severance, when you're ready.

**STATEMENT OF PAUL SEVERANCE, EXECUTIVE DIRECTOR,
UNITED SENIOR ACTION, INDIANAPOLIS, IN**

Mr. SEVERANCE. Thank you, Congressman Jontz, Congressman Costello. I appreciate the opportunity to be here. This may not be appropriate, but I think it's important to say that a lot of us are pretty discouraged about politics and politicians these days, and it seems to me that that's primarily because of the influence of money, big special interest money in the political system, and it seems that whether it's big oil companies or S&L crooks or pharmaceutical companies, people can essentially buy their way in Congress. That's the way it feels to a lot of us, anyway, but I know, and I'm glad to know, that that's not true of all politicians.

I just want to relay that I first ran into Jim Jontz when United Senior Action was presenting, trying to get through the Indiana State Legislature some legislation to better protect the rights of nursing home residents, and I assure you nursing home residents don't have any money to spread around the political scene. Nursing home owners have lots of money to spread around the political scene, and they do so. Yet despite that, Jim Jontz, who was then an Indiana State Senator, not only supported the nursing home residents' side on that, he lead the fight. I haven't been as close to Jim since he became a Congressman and went to Washington, but from what I hear about him, he's still sticking up for his constituents instead of the big money interests. So, I'm glad, Jim, that you have an interest in this issue because we need people like you in this matter.

It seems to us, and United Senior Action has spent the last year-and-a-half working and researching and looking into this whole issue of drug prices. I don't think the point needs to be made further that we have a crisis in this country in terms of the cost of prescription drugs. Our first panel was eloquent in describing that crisis. We talk to people every day who have to make the choice between filling their prescriptions, or maybe it's a choice between, you know, getting enough food to eat and filling their prescriptions, or maybe a choice between getting enough food to eat and cutting down my prescriptions and instead of taking three a day, take two a day or one a day and try to stretch that prescription out. That's not uncommon at all, not at all, and yet that's a very, very dangerous thing for the health of those people. So, I'm not going to belabor the fact that there's a terrible, terrible problem.

I do want to talk about pricing for a minute. Our approach is that the Indiana Senior Citizens Organization has been to go to the drug company that is in our State and talk to them, to Eli Lilly, about what they could do as a corporation voluntarily to try to deal with this crisis. The best way I can describe that experience in trying to deal with Eli Lilly on the issue of drug prices has been that it's been something like trying to deal with a cross between Atilla the Hun and Daffy Duck. They don't even admit there's a problem.

As you'll see in the statement from the Lilly spokesman today, that's what they told us. Our prices, they said, have gone up at less than the rate of inflation. We had done two surveys of Lilly drug prices since 1980, one from 1980 to 1992 and one covering the year

'91-'92. Both of those surveys showed that the wholesale price of Lilly drugs, the price that they sell to pharmacies where you and I have to go buy them, had increased at three times the rate of inflation for the last 12 years. Lilly said no, our prices have gone up at less than the rate of inflation.

Well, when we pressed them on that, then we began to get the story that the last panel here told, that they have this price index, and the price index includes all of the deep discounts—they call them chargebacks in the pharmaceutical business—that they provide to these major institutional buyers who can negotiate deep discounts because they have these restricted formularies, and they essentially say to the drug companies, hey, if you don't lower your price, we're going to use somebody else's drug. So, they can bargain.

So, they have this price index that's gone up at less than the rate of inflation, but it includes all of these discounts. We said no, no wait a minute. We're not interested in that. I mean, that's nice if the Veteran's Administration or the Defense Department or Methodist Hospital can buy drugs at deep discount. That's nice for them, but that doesn't help one of our members who has to go to the drug store to buy their drugs. We're not interested. We want to talk about the price that you, Eli Lilly, charge for drugs that are going to pharmacists where we have to buy them.

Do you know what they said? We don't want to talk about that. Well, I know why they don't want to talk about that. Because our surveys were taken right out of national publications that publish wholesale drug prices provided to them by the drug companies, and those surveys—our surveys of Lilly Drug show the same thing that the U.S. Senate Committee on Aging surveys show, drug prices increasing at three times the rate of inflation. That, folks, is plain and simple, price gouging of the public who has to go and buy their drugs at Mr. Webb's pharmacy. That's who's getting gouged.

What's happening with all this money from all these increases in prices? Well, the drug industry is the most profitable industry in the United States. I think somebody mentioned 15 percent average profit of the drug industry in 1991, as opposed to the Fortune 500 companies, was 3.2 percent. Eli Lilly's was 23 percent. Eli Lilly made, profit—profit—\$1.3 billion in 1991, 1 year. \$1.3 billion. Now, the drug companies love to talk about research. They love to talk about the cost of research and development. This statement from Lilly talks about that. Lilly plans to invest more than \$10 billion in research and development. It's a very competitive and very risky—well, this sounds like a tough business to be in, doesn't it? Who?

Well, it's so tough that Lilly has made record profits for over 30 years in a row. Every year, they've made more profits than the year before, for 30 years in a row—up to 1991, \$1.3 billion. What does profit have to do with the cost of research? Well, basically nothing. Profit is what you have left. You take all of your income and you subtract out all of your expenses, and profit is what you have left. So, the cost of research has already come out of their income before you get to profits. The \$1.3 billion is what they had left in profits, and who paid for that? Well, the Veterans' Administration and the hospitals did a little better because they could negotiate those discounts.

Who paid for that profit? All of us. Congressman Jontz, I think, raised one of the key issues in this besides profits, and that is the issue of marketing. The figure that I heard, Congressman, was \$5,000 per doctor that the drug companies spend on trying to get doctors to prescribe their drugs. The U.S. Senate Committee on Aging said that drug companies spend more money on marketing than they do on research. The love to talk about research, but they spend more money on marketing than they do on research.

What's the value of this? I mean, if you come up with a new drug, if you come up with Salk Vaccine when people are getting sick with polio, you don't need to spend a lot of money to convince a doctor to prescribe that. If you have a drug that's essentially the same thing as five or six other drug companies manufactured by other drug companies, then you have to spend a lot of money trying to woo that doctor, and that's exactly what they do. Because their business is not price competitive, it's extremely competitive. The drug manufacturing business is very, very competitive. They're out trying to convince those doctors like mad, but it's not price competitive, as the last panel indicated. A drug company doesn't sell more drugs if they lower the price, like most other businesses. Drug companies sell more drugs if they raise the price and do more marketing, and so we're in that non-price competitive. We hear this stuff about the free market, and it does not work in this business because it's not price competitive.

The only incentives the drug company has is to spend more and more and more money on marketing, which means everything from sending doctors on trips to deceptive and misleading advertising in medical journals, spend more and more money on that to get a bigger share of the market. That's how the marketing is. It seems to me, finally, that something is going to have to be done to control that.

I'm going to come to a close here, but the one response that Lilly had to us when we met with them was, well, we have an indigent program to provide drugs for those who can't afford them. How many of you have used that program? We asked them, okay, well gee, that's nice. Tell us, how many dollars worth of drugs did you provide on that program last year? You know what they said? We don't want to talk about that.

Mr. Scionti, if I got that name right—Scionti, thank you. I thought your testimony was excellent, sir, and you raised an important issue, or one that is at least very symptomatic of the gouging that drug companies are foisting upon the sick people in this country. You asked the question about the salaries of top executives. I have copies of these on the table out there. I have the answer to your question. This is the salaries of the top Eli Lilly executives. I'm not going to go through the whole list. You can see it for yourself. The first one is Richard Wood—this is 1991—\$6.5 million. We figured that out. If he works 50 hours a week and takes 2 weeks' vacation, that comes to something like \$2,600 an hour. Not bad. Who pays for that? Us.

So, Congressman, Jontz and Congressman Costello, we went into this whole business hoping that drug companies—and some have made public statements and made public commitments to hold down prices, although Lilly has completely refused to do that.

Since a few of them have done that, our hope that drug companies would take this problem seriously and begin to do something about it voluntarily is—that hope to us is fading fast, and I think that it's going to end up being in your laps. Hundreds of thousands—millions of Americans are going to be counting on what you do with this.

I don't certainly have all the answers, but it seems to me that your question is there anything that can be done less than a cap or some control, I don't see. We heard what they do, what the drug manufacturers do from this discussion from the last panel. If you try to, you know, alter the situation, make them provide the best price to Medicaid, well, then they raise somebody else's price. Yet, in effect, in other countries, there are in effect controls on prices. Drug companies sell drugs to Germany, or virtually every other industrialized nation in the world, the government says, this is how much we're going to pay, and it seems to me that we probably have to get down to that, and we have to find a way to end this terrible, ineffective and awful system of spending this huge, huge amount of money on marketing.

Doctors need a usable, objective way to get good data on drugs. Doctors don't need to hear about drugs from drug company detail people because they're getting misleading information anyway, and it's costing all of us huge amounts of money. It seems to me, probably we need to provide a way—I don't know what that is exactly, but we need to provide a way for doctors to get decent information and then not let drug companies build into their prices these huge amounts of money to sell their products to doctors.

I thank you very much for the opportunity to be here.

[The prepared statement of Paul Severance follows:]



UNITED SENIOR ACTION

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September 28, 1992

Testimony On Prescription Drug Costs
Field Hearing of the Subcommittee on Housing and Consumer
Interests
House Select Committee on Aging

by Paul Severance
Executive Director
United Senior Action of Indiana

Pharmaceutical Manufacturers' Price Gouging Must Be Stopped!

The title of a recent report issued by the Families USA Foundation tells the story: "PRESCRIPTION COSTS - AMERICA'S OTHER DRUG CRISIS". The issue of skyrocketing prescription drug prices has also been examined by the U.S. Senate Special Committee on Aging staff, by ABC Prime Time Live, and by other members of the media. United Senior Action has been examining the policies of Eli Lilly and Company. In every case in which an organization independent of the drug industry has studied this issue, the conclusion is always the same: America's pharmaceutical manufacturers are gouging the sick through rapidly escalating prices, huge marketing expenditures and unprecedented profits. Here's what Ron Pollack, executive director of Families USA, had to say about the findings of their study:

"Drug company lobbyists say skyrocketing drug prices reflect research needs, but the truth is that their pricing policies reflect nothing but greed."

This crisis is threatening the health and well-being of millions of Americans. Senior citizens are particularly affected because most seniors have to pay for their prescriptions out-of-pocket, and because seniors need more medicine. But Americans of all ages are being hurt. We talk to people regularly who are being forced to choose between filling their prescriptions and having enough to eat.

And the sad reality is that much of the suffering caused by escalating drug prices is not necessary at all. The pharmaceutical companies are price-gouging, plain and simple. They are taking advantage of the fact that people need their products to live, and that the consumer has very little choice.

PRICING HISTORY

Senate Special Committee on Aging staff reports have consistently stated that drug prices have been going up at a rate at least three times that of general inflation since 1980. The Families USA report found the same thing. United Senior Action has done two studies of Eli Lilly and Company drug prices: one covered 1980 - 1991. The other covered 1991 - 1992. These studies showed that Lilly prices had also increased at three times the general rate of inflation since 1980.

We have been trying to talk to Lilly officials about what they could do to voluntarily address this crisis. It's been like trying to reason with a cross between Attila the Hun and Daffy Duck. Lilly won't even admit there's a problem. They claim that their prices have increased at LESS than general inflation! But when pressed they had to admit that their price index includes deep discounted prices they charge to large institutional buyers like the Defense Department, the Veterans Administration, and hospitals. These institutions are able to negotiate deep discounts, called charge backs, because they can use their formularies (official guidelines on which drugs are to be used) to force drug companies to bid down their prices. But the consumer has no bargaining power, and so the consumer is getting gouged by the drug companies. When we asked Lilly to discuss the increases in prices they charge to wholesalers for distribution to pharmacies, they refused to talk about it! They said that wasn't relevant. But of course the truth is just the opposite. When Lilly deep discounts drugs sold to large institutions, that doesn't help the consumer who has to fill their prescriptions at all!

The only thing that is relevant to the consumer is the price at the pharmacy, and that is driven by the manufacturer's price. So when Lilly tells you that their prices have gone up at less than the inflation rate, don't believe it for a minute. There is about eight Lilly drugs that constitute 80-90% of all Lilly drugs sold at pharmacies, and Lilly's wholesale price for those drugs have been increasing at three times the rate of inflation for 12 years. And that is price gouging!

PROFITS

The pharmaceutical manufacturing industry is the most profitable industry in America. Pharmaceutical manufacturers profits averaged five times the Fortune 500 companies average in 1991. Eli Lilly's profits were seven times the Fortune 500 average. Lilly's profits in 1991 were 1.3 BILLION DOLLARS. Those profits

come out of the pockets of sick people who need those medicines to live.

RESEARCH

Drug companies say that high profits are necessary to fund the high cost of research. All of us are grateful for the successful research done by the drug companies. And no one wants research curtailed. But the constant cry of research costs by the drug companies is just a smokescreen for their price gouging. Profits are net income after all costs of research are paid. Eli Lilly and Company, for example, has had record profits for 30 years in a row. So their profits have nothing to do with research costs.

MARKETING

Senate Committee on Aging Reports have documented that drug companies spend more money on marketing than they do on research. This amounts to billions of dollars every year that drug companies spend to try to influence doctors to prescribe one company's brand names over some other company's similar drugs. And all of this is paid for by sick people who need those medicines to live.

This tragic waste happens because prescription drugs are not price competitive. The doctors who prescribe the drugs rarely know the prices. And the sick people who have to buy the drugs have no choice. So there's no real incentive for the drug companies to hold prices down.

On the other hand, the pharmaceutical industry is very competitive. Most drugs have have any number of competitors in the same class. And the way drug companies increase their sales is to increase their marketing efforts with physicians. These marketing efforts have been well documented to be full of expensive abuses: everything from cash payments for "frequent prescribers," to free cruises, to free dinners and shows, to millions of dollars of gifts and "reminder items." All paid for by sick consumers.

Drug companies describe their marketing programs as "physician education." But it has been equally well documented that these marketing programs, including advertising in medical journals, are full of deceptive and misleading "education" for physicians.

When we asked Eli Lilly and Company officials to detail their marketing expenditures to us (after they gave us volumes of data on research expenses), they refused to give us any of that information, saying it is "proprietary." Why would marketing data be more sensitive than research data? For only one reason. Because it is embarrassing to the drug companies to have the public know how much they spend on marketing. And they should be embarrassed!

EXECUTIVE SALARIES

Another demonstration of drug company price gouging is executive salaries. As an example, Eli Lilly's president was paid \$6.5 million in salary, bonuses, and performance awards. Other Lilly executives were also paid outrageous amounts. All paid for by sick people who need their drugs to live.

Mr. JONTZ. Thank you. Mr. Lancaster, please proceed.

STATEMENT OF BOB LANCASTER, MEMBER OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)

Mr. LANCASTER. Good afternoon, ladies and gentlemen. I want to thank Congressman Jontz and Congressman Costello for inviting me to be a part of this panel. My name is Bob Lancaster. I don't live in Rochester. I live at Lightersford. How many have ever heard of Lightersford? Hey, how about that? Jim's been to Lightersford many times.

Mr. JONTZ. I knew that you lived in Lightersford. I apologize and correct that for the record.

Mr. LANCASTER. I'm a member of the AARP State Legislative Committee, and we're very much concerned about the drug situation in Indiana. AARP has over 700,000 members in Indiana. That's a lot of people, and we have a saying in AARP. I hope some of you have heard this. "Pocketbook thinking will keep you from sinking." Now, with these drug prices, we're having a hard time thinking about our pocketbooks.

Now, a large portion of our members use prescription drugs, and many of our members are on fixed incomes. Many just barely exist at the poverty level. Poverty level. That's terrible, isn't it, in a great country like America? They're forced at times to choose between buying food or buying their prescription drugs. That's a terrible choice to make.

Maybe some of you wonder what kind of a medical problem do I have. Well, I got a little bit of elevated blood pressure, and I think that's been brought on more by the fact that I see all through the State of Indiana how our senior citizens are being treated, and it's going to raise anybody's blood pressure. We need to raise the blood pressure at the government level.

These members, they need some answers. They want to know why these drug prices keep going up, some as many as two, three, four times a year. Why? They're asking a lot of questions, and I'm going to be brief with these questions. Our membership asks questions, and I want you to know, that they also vote. We, as senior citizens, we have the best voting record in the country.

The would like to know why drug prices increase at over three times the inflation rate. They want to know this. Why are prescription drugs 25 to 40 percent higher for Americans, that's you and I, than they are for foreign countries. Why? Why does it cost more?

Paul just mentioned that the president of Eli Lilly gets a salary of approximately \$6.5 million—in the neighborhood of \$6.5 million. I'd say he lives in a pretty good neighborhood, wouldn't you? The average Fortune 500 company has a profit of approximately 3 percent. Eli Lilly was over 20 percent. Why?

The AARP membership has many, many more questions, but to respect the time that we have left, I want to thank Jim Jontz, Representative Costello for having me, and I want you to know that AARP is going to keep on this issue as long as we're able to do it. Thank you.

Mr. JONTZ. Do you have any questions, Mr. Costello?

Mr. COSTELLO. I just have one question, real quickly, for Mr. Severance. What further steps does your organization plan to take in terms of dealing with this issue, and specifically with Eli Lilly? I appreciate that there was a meeting recently and that—I'm not sure what happened as a result of it. I guess maybe I'm asking for you to share any information about that that you think is pertinent for our hearing.

Mr. SEVERANCE. Well, the meeting that you refer to, Jim, was attended by representatives of six State-wide senior citizens organizations with officials of Eli Lilly and, as you can guess from my statement, that meeting didn't really accomplish anything. As I said, they didn't want to talk about the increases in their wholesale prices. They didn't want to talk about what their marketing costs were. They didn't want to talk about how much money they spent on their indigent program. We cited the fact that six other drug companies in this country had made written public commitments that they would hold price increases to under the inflation rate and asked if Lilly would develop and adopt a policy of price restraint—price restraint on future prices. They said no, they would not do that.

We asked if they would continue the dialogue with senior organizations by scheduling another meeting, and they said no, we don't want to meet anymore. So, that's where we stand. We intend to take to the Lilly stockholders meeting next April, essentially to ask the stockholders to overrule the management. We don't feel that the management of Eli Lilly is willing to take this issue seriously, and we intend to go to the stockholders with a resolution. Our organization holds stock in Lilly, and we're going to present to the stockholders a resolution that they demand that the management of Lilly do what some of the other drug companies have done, and that is make a commitment about price increases, and to limit their salaries of their executives to some reasonable level. So, that's essentially our next step.

Mr. COSTELLO. Another very quick question. The issue of research costs. It would seem to me that institutional purchasers get the benefit of research costs, just like individual customers do, and so is there any rationale that you can see in terms of asking individual customers to bear what apparently is a disproportionate share of the costs of this research? Is there some reason for that that you're aware of?

Mr. SEVERANCE. I can see no reason whatsoever. When Eli Lilly or one of the other drug companies sells—they sell their drugs in bulk to a wholesaler anyway. It really doesn't cost them anymore to provide drugs to a wholesaler that turns around and ships them out to pharmacies than it does to provide them to, you know, a major hospital or the Veterans Administration or whatever. So, why these deep discounts to major institutional buyers from the—there's only one reason that the institutional buyers get deep discounts, and that's because they can use those formularies to bargain for price.

Is the research the drug companies do of any less value to people that get their drugs from the Veterans Administration or a hospital than from Mr. Webb's pharmacy? Absolutely not. Is it fair that individual customers who have to buy their drugs in pharmacies

pay much more than these institutional buyers? Absolutely not. It's plain and simple price gouging because the individual customer is defenseless in that while the big institutions are not defenseless.

Mr. JONTZ. I want to thank this panel. I would hope that you would keep us—I have not asked you your views on specific bills that may be pending before the Congress. We won't take the time for that, but I would ask you, if and when there is legislation that your organizations are supporting feel has merit, please let me personally know, and I think our committee would be interested in your views as well.

Mr. SEVERANCE. I'd be glad to do that.

Mr. JONTZ. Let me dismiss this panel, and ask our final witness to come forward. Julie Newland is the manager of public affairs for Eli Lilly and Company. I want to say as she comes forward that we certainly appreciate Lilly sending a representative today, and they could expect to receive—

Ms. NEWLAND. We grew by two.

Mr. JONTZ. I'm sorry?

Ms. NEWLAND. We grew by two.

Mr. JONTZ. Okay. Well, I'll have you introduce the two members of the panel who are with you in a minute. I just want to say this. I appreciate Lilly being here. You knew that when you came there would be some criticism that you'd be expected to respond to. I think all of us in this State have had our lives touched by the presence of Eli Lilly some way or another. The impact of the company on our families and our State goes without saying, and I think we're hoping that the company will have some answers to some of these issues, and so we appreciate you coming today. If you want to proceed as you see fit, introduce your colleagues or associates on this panel whenever the appropriate time is, please proceed as you see fit. Thank you.

STATEMENT OF JULIE NEWLAND, MANAGER OF CORPORATE AFFAIRS, ELI LILLY AND COMPANY; ACCOMPANIED BY TIM MCCARTHY, ENVIRONMENTAL SPECIALIST, AND JIM DISHONG

Ms. NEWLAND. Thank you, Congressman Jontz, Congressman Costello. Again, my name is Julie Newland, and I'm manager of corporate affairs for Eli Lilly and Company. Congressman Jontz didn't recognize, but I will note the fact that I used to work for him many years ago in the Indiana House of Representatives when I was on the staff there, so I've known Jim for quite a long time. I want to thank you for this opportunity to allow our corporation to come in and to present some information to you which I think will be very important to you and to Congressman Costello and the members of the audience.

What I would like to do just quickly now is to introduce my—I said we grew by two people since we first came out, but introduce two persons who work for Eli Lilly and Company at our two plant sites, and then I will go ahead and make some brief comments and then allow them to make brief comments, but will still recognize the time constraints that you're under.

To my immediate left is Tim McCarthy, who is an employee, an environmental specialist at our plant site in Tippecanoe County. To

his left is Jim Dishong, who is at our plant site near Clinton, Indiana, which as I understand it, is now in your Congressional District.

At Lilly, our major emphasis is on research, but in general, we also develop and manufacture and market pharmaceutical products, medical devices and diagnostics, and agricultural products. As was mentioned, our corporate headquarters is in Indianapolis, and here in the State of Indiana, we employ over 13,000 people, and we employ over 30,000 people worldwide. We do have four plant sites here in Indiana, one in Indianapolis and one in Greenfield. At our Tippecanoe facility, we employ 1600 people, and in our Clinton facility, we employ 1350 people. Many of these people are in this room today, and also they and their families live in Congressman Jontz's district.

The employees of Lilly take a lot of pride in the important role that they play in the health care system. I can't tell you how exciting it is for many of our employees to take part, to have a job where they actually can help provide a benefit in the health care system. It's a little different than making widgets or making cars—no disrespect intended, but it's a very exciting job and a role that we play in the health care system. We actually help people to live longer and happier and healthier lives, and that's something that we're very proud of. We work very hard at trying to find tomorrow's miracle drugs and today's miracle drugs, and it takes a lot of effort and a lot of work on the part of a lot of people in this State and around the world.

We're here today because Lilly also, as many of you have expressed, we're very concerned about the prices of pharmaceutical products, and we want you to know why pharmaceutical products cost what they do. There's been a lot of information. There have been a lot of numbers thrown around, but I will hopefully try to shed a little light on some of these issues and to provide more clarification.

Our employees at Lilly take very seriously the responsibility that they have, and the corporation takes that responsibility very seriously, not only to our employees, but also to their families, to the customers that we have, and to the neighbors and to the communities in which we work, and to our stockholders. We believe we have an outstanding record of ethical business practices, and that we are an outstanding corporate citizen here in the State of Indiana.

To be quite honest with you, though, our company, our employees, and many of them that are here today, have become somewhat weary with the unfair and misguided attacks regarding our prices of our products, and more so about our marketing practices. I would just want to make one point unique somewhat perhaps to Eli Lilly and Company, over half of our sales reps, the young men and women who provide information to pharmacists and physicians about our products, over half of them are pharmacists, which shows the level of professionalism and education and training that these people have. We do have one such person here today, if any of you would like to chat with her after this hearing. She can provide you with some information about the quality and integrity of our sales force, and especially given their background and training.

There are three key points that I would like to make regarding the issues that have been raised about pharmaceutical drug prices. The first point is that it cannot be forgotten, and several people on earlier panels did mention the point, that medicines are the most cost effective form of health care. It's because of the discovery and research that has taken place at Eli Lilly and Company and other pharmaceutical manufacturers that are research based. You can now take a pill for an ulcer condition as opposed to having to undergo hospitalization and surgery. You can take a pill for pneumonia or another infection and not have to miss days from work. You can take medicines for a cardiac condition and avoid a very painful and lengthy hospitalization and surgery. You can also now, because of the research and development of Eli Lilly and Company, take medicine for depression and not have to undergo lengthy hospitalization and other related problems.

These are examples of some of the human benefits of the work that we do, but let's talk a little bit about numbers because everyone is very interested in the numbers. With the example that I gave about the ulcer treatment, the ulcer condition, a person can take that medicine for ulcer therapy, the drug, the medicine. That would cost about \$500. That same person, to undergo surgery for ulcers, would be \$24,000. You can do the math and see that the cost effectiveness of the medicine is much greater.

The annual cost for cardiac medications would be around \$1,000. That same person who would have to undergo cardiac surgery, that cost could run \$40,000. Hospitalization for schizophrenia could run as high as \$75,000, contrasted with \$4,500 for medical therapy, medicines. In the last few decades, because of the work, the research, the efforts of people at Eli Lilly and Company and in other companies, we've been able to virtually eliminate many diseases that 10, 20, 30 years ago would have killed people. They would have died from these diseases, such as polio and smallpox.

The second issue. When we say the medicines are cost effective, we must understand what that means within the context of the entire health care picture. Prescription medicines are 5 cents, a nickel, of every health care dollar spent. A few decades ago, it was 10 cents of every health care dollar, so actually, the cost for at least the prescription drug piece of the health care dollar has gone down.

Proposals that would focus on just that one small segment of the health care economy such as freezing drug prices, can only result in smothering the advances of medical technology. Let's make one point right here. If you were to erase every profit, every penny of profit in the pharmaceutical industry, the savings to the health care system would be less than 1 percent.

The third point, and it was mentioned before, is probably to us the most important point, especially to our employees, is the investment that a company such as Eli Lilly and Company makes to research and to develop medicines. Lilly plans to invest more than \$10 billion in research and development during this decade, and there is no guarantee of success. As stated, this business is very competitive, and it is very risky. Out of the 100,000 possible compounds that our researchers will look at or investigate, only 10 of those will actually make it to market, and out of that 10, only two

will return a profit. It is those two products, those two that are out on the market, that we must—the profit from those two products must fund the years of research and development for the lifesaving medicines for our children.

Trying to recoup those expenses becomes increasingly difficult because, on a 17-year patent, we actually only have 5 to 7 years for that product to be out on the market to recoup the expense. Also, the costs of research and development will continue to grow because of the complexity of the diseases that we are now trying to find cures for or trying to treat, such as Alzheimer's, cancer and AIDS. Those diseases are much more complex than the diseases of the past. Clinical trials continue to grow and to become more expensive for us. Those all add to the research and development costs. Still, if we do not continue to make this investment and continue along this same path, if we think health care costs are high now, imagine how much higher they would be 10 years from now if this research effort stopped.

A point was made earlier about the rebates that the pharmaceutical companies paid to State Medicaid programs. Eli Lilly and Company alone last year paid \$50 million to State Medicaid programs for the rebate, as was mentioned. These are all very important facts that we think need to be understood in order to have a better grasp of the notion of drug pricing and to give it any logical and fair consideration.

Again, we will State that since 1970, the average Lilly prices have risen at an annual rate of only 4.5 percent, which is less than the average annual increase in general inflation, which was 6.3 percent. Price controls kill innovation every time. Where would we be now if 20 years ago, the government had decided to freeze our prices? What products would not now be available to us to use?

We know that the criticisms of our drug pricing policies are focused primarily on prices at the retail level. We could also make the argument that part of that expense is perhaps the result of the failure of third party payers, insurance companies, businesses and others, to not cover pharmaceutical benefits in their plans or to charge an additional co-payment or out of pocket expense for the recipient.

Eli Lilly and Company is not insensitive to the difficulties faced by poor people in trying to pay for their prescription drug medicines. We do, as was mentioned earlier, have an indigent drug program. If you would like more information about that, we have some booklets, but you can ask your physician. They will contact the company, and we can provide information about our indigent drug program.

Another point that was raised is the excess of profits of our company. I would like to again raise the point made earlier that if all the profits from our industry were removed, it would effect health care less than 1 percent. It's these profits that must pay for tomorrow's research.

There is one thing, Congressman Jontz, that we believe the Federal policy makers could do to help to some extent with the issue of drug pricing, and that is to allow us the true patent life on our products. As I mentioned earlier, right now we only have 5 to 7 years in the marketplace to recoup the expense. We believe if we

were allowed the true patent life, that that would probably go a long way to helping to deal with that problem.

In conclusion, we do appreciate the opportunity to address your subcommittee and to make these comments. We ask that you please bear those three points in mind when looking at possible health care proposals, and that when you do consider those, that whatever proposals are moved forward, that they not destroy the incentives that we have to discover new and innovative breakthroughs. We're very proud of the role we play in the health care system, and we're very proud of the quality of life that we can provide for our citizens and our employees here in this State.

I would now like to have Tim McCarthy talk to you a little bit about some of the expenses as we've seen growing over the past, or most recent time, in the environmental area.

[The prepared statement of Julie Newland follows:]

**TESTIMONY OF JULIE NEWLAND, MANAGER OF CORPORATE AFFAIRS,
ELI LILLY AND COMPANY, SEPTEMBER 28, 1992**

Hello. I am Julie Newland, Manager of Corporate Affairs at Eli Lilly and Company. At Lilly, our major emphasis is on research, but in general, we develop, manufacture, and market pharmaceutical products, medical instruments and diagnostic products, and agricultural products. Our corporate headquarters are in Indianapolis. We employ over 13,000 people in Indiana and over 30,000 people worldwide. The employees of Lilly take pride in the important role we play in making products that help people live longer, healthier, and more productive lives, and in discovering many of tomorrow's miracles. I am here today representing Lilly because we, too, are concerned about the prices of pharmaceutical products and we want people to know why pharmaceuticals cost what they do.

We at Eli Lilly and Company take very seriously our responsibilities to our employees, to our customers, to our neighbors and communities, to our suppliers, and to our stockholders. We have an impeccable record of ethical business practices and of being an outstanding corporate citizen in the communities in which we operate. Here in Indiana, we have three plant sites: near Clinton, in Lafayette, and in Greenfield. At our Clinton facility, we employ 1350 people, and at our Lafayette facility we employ 1600 people—many of those employees and their families live in this 5th congressional district.

Our company, our employees, have become weary with the unfair and misguided attacks regarding the prices of our products. We are pleased to have this opportunity to present you with information to provide a better understanding of this issue.

First, and foremost, it cannot be forgotten that medicines are THE most cost effective form of health care. Because of the discovery and research conducted by our employees and others, people can take medicine to treat an ulcer condition and avoid surgery; not miss days at work because of pneumonia; avoid surgery for a cardiac condition; and not have to undergo a lengthy hospitalization because of depression. These are examples of the "human" benefits of medicines—they do not reflect the bottom line dollars and cents of health care savings. For example, annual drug therapy for ulcer would be \$500.00 compared to \$24,000 for surgery; the annual cost for cardiac medications would be \$1,000 compared to \$40,000 for cardiac surgery; hospitalization for schizophrenia would run \$73,400 compared to \$4,500 for medication therapy. And just in the last few decades, through the use of medicines, we have been able to virtually eliminate polio, smallpox, and other diseases that would have resulted in death.

Second, when we say that medicines are cost effective, this point must also be understood within the context of the entire health care picture. Prescription medicines are only 5c. of every dollar spent on health care!

The third point is the enormous investment a company such as Lilly makes to research and develop a medicine. Lilly plans to invest more than \$10 billion in research and development during this decade with no guarantee of success. This business is very competitive and it is also very very risky. Out of the 100,000 possible compounds that the industry investigates, only 10 will make it to market. Of that number, only 2 return a profit. It is these two products that must fund the years of research to discover the life saving medicines for our children.

These are very important facts that must be accepted in order to give the issue of drug pricing any logical and fair consideration. With regard to drug pricing, Lilly has shown tremendous restraint in its price increases. Our overall price increases have been at or below the CPI. Since 1970, average Lilly prices have risen at an annual rate of only 4.5% which is less than the average annual increase in general inflation.

Eli Lilly and Company is not insensitive to the difficulties faced by poor people who cannot afford our drugs. Lilly does provide an indigent drug program as do numerous other drug companies.

In conclusion, we appreciate the opportunity to provide our comments on this very important issue. We ask that you please bear in mind the cost effectiveness of medicines and that as you consider the proposed solutions for reforming the health care system that you not destroy the incentives to discover new and innovative breakthroughs. We are proud of the part we play to enhance the quality of life for our citizens, and to provide the good paying jobs for thousands of Hoosiers.

Mr. JONTZ. From the standpoint of time, and I have to be sensitive to Congressman Costello's schedule to catch a plane, I would be delighted to have material submitted for the record about the expenses of Mr. McCarthy. If you have some general dollar figures you want to give just right up front, please do that, and then we'll submit the rest of the material for the record.

Mr. McCARTHY. I have a little bit different perspective on this. Again, I'm Tim McCarthy. I'm an environmental specialist in the Chemical Processing and Development Group at Tippecanoe, and basically the things I wanted to get across were some of where the profits went.

One of the most significant places where our profits are going now, not only in R&D, but is also the costs of environmental compliance and environmental costs in general. Just to give a quick number, right off the top, Eli Lilly spent \$600 million in the last 5 years in capital environmental expenditures. That doesn't include \$30 million a year just to keep the environmental systems running; \$600 Million of new buildings, new equipment, state of the art equipment to meet environmental obligations; \$200 Million of that were spent at Tippecanoe labs, and Clinton as well has a similar record.

We invest in buildings before we even have a drug to put them in. We have to predict the types of things that we need for a new product and have all of those environmental controls without even knowing if the FDA is going to approve them. So, that's where the risk factor comes in.

I have lots of other data.

Mr. JONTZ. I do appreciate that. I would ask that you submit it for the record at this time.

Mr. McCARTHY. Okay, that's fine. I will. Thank you.

Mr. JONTZ. Great.

Mr. DISHONG. In deference to our time situation, I'll keep my comments very brief. My name is Jim Dishong, Congressman, and I'm a resident of Hillsdale, which is now with the re-districting, part of your district. I'm a representative of the Clinton Laboratory's plant site, of which a large number of our employees are constituents as well.

I'd just like to leave the group, I guess, with this thought because of our time situation. What Tim did not really have a change to do justice to is the incredible rise in the costs associated with being in the pharmaceutical manufacturing business. These costs are increasing dramatically, and you've heard discussion time and time again from panel members that have preceded this panel with regards to putting a cap on pricing.

Well, the reality of a cap on pricing with dramatically rising costs is that the profitability that folks earlier mentioned we wanted to protect, obviously when you do the math, would erode, and with that goes jobs. There are 13,000 Hoosier jobs involved in Eli Lilly Company alone. There are 1350 at the Clinton plant site, not to mention the secondary effects of the industry of which we participate. In fact, at one point at Clinton, we had over 2,000 contractors on site, even though we had just 1350 employees. So, I think it's important that as different types of remedies are discussed, that it's with great caution that folks pursue those kinds of

things that address one very small part of the overall health care expenses.

Thank you.

Mr. JONTZ. Let me ask a couple of questions, if I could. I'm not sure that I—I'm not an accountant, and I don't understand exactly how these sorts of things are done, but my impression is profits is what's left over after you spend money for all of the things that you have to spend money for—salaries, capital expenses, environmental controls, research. That when you spend all those things, that then what's left over, the difference between the receipts that the company has and the expenditures, are profits. Am I mistaken about that?

Mr. MCCARTHY. I've been told that capital expenditures actually come out of our profit line.

Mr. JONTZ. Well, I don't understand. When you say they come out of your profit line—

Mr. MCCARTHY. Those profits are used for capital expenditures like new buildings.

Mr. JONTZ. Those are not profits that are paid as dividends?

Ms. NEWLAND. That also.

Mr. JONTZ. So, how much of the \$1.3 billion in profits—how would they be profits if they're used for expenses? How much of the \$1.3 billion—

Mr. MCCARTHY. I'm not an accountant. I can't answer that.

Mr. JONTZ. How much of the \$1.3 billion is used for capital expenses?

Ms. NEWLAND. Congressman Jontz, I don't have the figures in front of me for our capital expenses. I think the point is that it's the profits that have to fuel the research for tomorrow, not the expenses of yesterday.

Mr. JONTZ. Well, I guess it would seem to me that whatever you spend on your scientists, which is very important. The comment is not meant to diminish in any way the importance of research, but I would think that whatever the payroll is that you have for your scientists who do the research and all the supporting expenses, that that's an operating expense of the company, and that you couldn't—if you told your stockholders you made \$1.3 billion but oh, well, \$400 million of that really weren't profits because we spent those for this and \$200 million, that wasn't really profits because we spent that for that, I would say as a stockholder, you didn't really make \$1.3 billion of profits, that those were ongoing expenses. I guess I don't understand how something can be an expense for research and be a profit. It seems to me that expenses for research come out of your gross, but they don't come out of the profits.

Mr. MCCARTHY. I didn't say that the R&D came out of the profit line.

Mr. JONTZ. Well, I didn't—you did not, that's correct. But I'm just trying to understand how something can be an expense and then—I thought that you took out the expenses first before you calculated the profits. Could you provide for the record a breakdown of where that \$1.3 in profits went?

Mr. KLECK. Julie, can I help with that?

Ms. Newland.

Mr. KLECK. My name is Jim Kleck with Eli Lilly. About 45 cents out of every dollar of profit goes to dividends to pay the shareholder. The other 55 cents goes to fuel our capital expenditures for building for the future. Over the last several years, Eli Lilly and Company has invested over \$1 billion a year in the future growth of the company, and that's some of the things that Tim was referring to in regards to the capital investment that we're putting in environmental areas.

Mr. JONTZ. And that's all capital?

Mr. KLECK. That's all capital.

Mr. JONTZ. Okay. That's not research expenses. It's capital.

Mr. KLECK. It's not research. It's capital.

Mr. JONTZ. Okay, so research is not in profits, but capital is?

Mr. KLECK. Yes.

Mr. MCCARTHY. Yes.

Mr. JONTZ. Okay. Well, we're making some progress. Let me ask another question, if I could. Did you come prepared today to explain what has been the rate of increase in the price charged to wholesalers for your drug products, as compared to the overall price increase, which you did provide for the record?

Ms. NEWLAND. The information that I provided was the rate of increase for our entire Lilly price index, which was the same information we provided before.

Mr. JONTZ. So, will you provide information on what you—the price increase to wholesalers? Can you do that or will you do that on some future occasion?

Ms. NEWLAND. I will certainly be happy to go back and check on that for you.

Mr. JONTZ. You're telling me that you have that number and you will provide it but you just can't provide it today?

Ms. NEWLAND. I'm telling you I'm sure we have that number. I have to check and see what our price increases may or may not have been to the wholesalers. I'm not going to, you know, garner a guess now.

Mr. JONTZ. Okay, but I'm asking whether you will make a commitment to provide for the public record what the increase has been—even if you don't have the number today, which I appreciate that you don't, but would you provide that for the record so that we would have an understanding of how the increase to wholesalers compares to the increase in overall product? Would you be willing to do that at some future date?

Ms. NEWLAND. Certainly.

Mr. JONTZ. Okay. Well, I think that if you could provide those numbers, it would sort of help dispel some of the—or help clarify. I don't know if it will dispel or not any of the controversy, but it certainly would help clarify.

Ms. DECOURDREAU. My name is Alecia DeCoudreaux. I'm also with Lilly. To the extent that we can provide information to you that is not proprietary information, we are happy to go back to our offices and to determine what information we can. We cannot make a blanket commitment, however, because we cannot provide any information that is proprietary.

Mr. JONTZ. Okay. Well, I guess it would seem to me that we're looking for one figure, which is the prices to all of your wholesaler

customers, and how much that's increased, and I don't know my own self how that would be proprietary.

Congressman Costello is going to have to excuse himself shortly, and I apologize that we have to rush you here, but what questions do you have at this point?

Mr. COSTELLO. Two quick questions. How many people last year in 1991 were served under the indigent drug program at Eli Lilly?

Ms. NEWLAND. Persons? Alecia, do you know? I don't know off the top of my head.

Mr. COSTELLO. Do you know how much money was spent in the indigent drug program last year? Can you provide that information to us?

Ms. DECOUDREAUX. We don't know.

Mr. COSTELLO. The company does not know how much was spent—

Ms. DECOUDREAUX. As we sit here now, we do not know.

Mr. COSTELLO. But can you provide that information to us at a later date?

Ms. DECOUDREAUX. We would certainly be happy to check and to the extent that there's any information that is not proprietary, we will attempt to provide it to you.

Mr. COSTELLO. Mr. Severance made a statement earlier in his testimony that several senior organizations recently had a meeting with Eli Lilly, and apparently at the end of that meeting, according to his testimony, Lilly said that they were not interested in meeting again, holding another meeting in the near future. Is that correct?

Ms. DECOUDREAUX. Actually, I might answer that because I'm the person who spoke with Mr. Severance when he came to visit us at Lilly. What we said to Mr. Severance then was that if the purpose of any future meeting was for us to discuss the same questions and for him to ask us the same questions that would cause us to provide information that was proprietary, we didn't see that it would be fruitful for us to meet under those circumstances. We did not refuse to meet or talk with him at all. We said that it did not make sense for us to meet and discuss things over which we could not really come to any agreement or things that would cause us to provide information to him that was proprietary.

Mr. COSTELLO. I would only request of Ms. Newland that if you would, would you submit information to this committee in the next few weeks concerning the indigent drug program and how much—both how many indigent persons were served last year in that program and how much was spent by the company.

Mr. JONTZ. I want to thank Congressman Costello for joining us, and wish him a good trip home. I have a couple more questions, and we'll just ask at this point if the patience of the audience can be tested just a little bit further.

I'm not sure I understand this whole issue of proprietary information. Is what you give to the United Way proprietary information?

Ms. DECOUDREAUX. Again, maybe I can help. As we sit here, we are not comfortable that any of us who are here today know enough about what goes into our expenses to be able to provide the information you're asking for. All we're saying to you is that we

will go back to our offices. We are happy to talk with our people who do have that information, and to the extent that we can provide it to your without violating anything that is proprietary, we will be happy to try to do that for you.

Mr. JONTZ. Well, I guess what I'm trying to understand is how what you spend in this program would be proprietary.

Ms. DECOUDREAUX. And I'm saying to you it may not be, but because I do not know, I don't want to answer you. You've asked for a very clear commitment that I may not be able to meet. If we can provide that information without violating anything that is proprietary, we will be very happy to do that. We, of course, ask the question why is that relevant? If what you're concerned about is making sure that products are available for patients who are not able to pay for them, we have a program that all they have to do is speak with their physicians, have their physicians contact us, and we will provide those products to them. So, we too would like to know why that's even relevant information. But all I'm saying to you is that as I stand here, I don't have the answer to your question. If I can get it for you without violating anything that's proprietary, we will be happy to do that.

Mr. JONTZ. Well, I appreciate that, and I hope that you can. Obviously, the reason it's important is so that people can judge the extent to which the company is committed to this. Now, I'm not sure whether, you know, now that Ms. Jameson from our first panel is aware of this program. I'm not sure to what extent part of her \$325 prescription drug bill every month is the consequence of the purchase of Lilly products. I don't know which of those brand names are yours and which are not.

Ms. DECOUDREAUX. Quite frankly, we would hope that more of the products that senior citizens take were ours, but unfortunately, they are not. Of the top products that senior citizens take, we do not make those products. I don't know that any of the information that you've asked for will actually help to show the extent of our commitment to the indigent drug program. I will say to you, however, that we have recently participated with several other pharmaceutical companies in providing information to the general public about our program in the form of a booklet, and I believe we brought that booklet along with us to distribute today. So, to the extent that we are committed, we've certainly come out very publicly and stated that we have such a program. We've publicized information about it, and we have that information with us today.

Mr. JONTZ. Okay. Let me ask an additional question if I could. Would you be able today, Ms. Newland, or on some future occasion, provide for the record some data on marketing expenses for the company? Say, for the last 10 years, and how those compare to research expenses?

Ms. NEWLAND. I would certainly be happy to check, and if it is not, as Alecia said, propriety information, then we can provide it. It would seem to me information that delineates the amount of money—this would be somewhat competitive information—would be proprietary.

Mr. JONTZ. Well, I'm not sure. I guess I will have to do some inquiry as to whether any other companies have provided this information or not. For some way, the Select Aging Committee on the

Senate side has some industry-wide figures which indicate that in 1991, drug manufacturers spent approximately \$1 billion more on marketing and advertising than on research, according to their own data. Now, I don't know which companies released what. This is something which our committee is going to have to get into, and if we find that other companies are releasing information and claiming it's not proprietary and Lilly is not, that is going to be difficult to explain.

Now, perhaps other companies are not releasing this information, or maybe they're not releasing as much as Lilly is, although I guess we don't have any information on marketing expenses. But it seems to me that if your argument is that it's research and not marketing expenses which are the cause of the prices which consumers pay, I would think it would be in your interest to release the information and say that this is what we spent on marketing and this is what we spent on research, and there be some gray area in there which you all can quibble about, but I would think it would be in the interest of the company to set the record straight on that matter and that you would welcome the opportunity to do that.

Ms. NEWLAND. Well, we would welcome that opportunity. I can tell you one figure is we have spent \$800 million this year in research and development costs. Now, your other question was with regard to specific marketing expenses.

Mr. JONTZ. And that isn't proprietary information, that \$800 million you spent on research?

Ms. NEWLAND. That's published in our annual report.

Mr. JONTZ. Okay, well what about the marketing expenses? Are those published in your annual report?

Ms. NEWLAND. I don't know if they're broken down or how you define marketing expenses.

Mr. JONTZ. Why would what you spend on research not be proprietary but what you spent on your indigent program would be proprietary or what you spent on your marketing program would be proprietary?

Ms. DECOUDREAU. At the risk of being repetitive, I've not said that the information is proprietary. I have said that I don't have the information. I will go back to our office and check. To the extent that the information is not proprietary, we will attempt to provide it to you. The things that are listed within our annual report are clearly matters of public record, and it is for that reason that we're very comfortable today in coming to you and giving you those numbers. With respect to anything else that is not a matter of public record, we do need to protect our competitive interests.

Mr. JONTZ. Sure. Well, I guess someone in the company makes a decision about what goes in the annual report and what does not, and perhaps this next year's annual report will include additional information, but it's just perplexing to me as to why one category of information is proprietary and one is not.

Let me make two other points, and you can respond to this, if you will. Your testimony dealt at some length with the cost effectiveness of using drug products, and that obviously is important, but it seems to me that the cost effectiveness of the product really is not the only issue. It seems to me the other issue is are people

being charged more than they should, because even if you have a very cost effective—even if it's very effective to use cardiac medications for \$1,000 compared to \$40,000, if a fair market system would mean that consumers only pay \$500 instead of \$1,000, it really is immaterial that it's more cost effective than the cardiac surgery.

It just seems to me that that's an issue that is central in this debate, and that is, are people paying more for prescription drugs than they should? The issue isn't—if this weren't cost effective, people wouldn't be interested in getting prescription drugs. The reason they want them is because they're cost effective. If they weren't good products, people wouldn't want to go out there and purchase them, and doctors wouldn't be prescribing them. But that does not justify charging more to any person than what they should have to pay. I want to sort those two questions out because they really are separate questions.

The other point that I'd like to make, your testimony with regard to well pharmaceuticals are only 5 percent of the total health care expenditures and if we eliminate profits completely from the scene, then that would only be 1 percent of the total health care expenditures, reminded me of the testimony that I heard when I did town meetings earlier this year on health care costs, and the doctors and the hospitals and the insurance companies, everybody else out there said well, we're only X percent of the total cost of health care expenditures, and so you know, please don't focus on us because we're only this much percent.

Well, you know, I think that we do have to deal with health care expenditures in the totality, all \$700 billion of them each year, but it seems to me that that doesn't exempt anyone out there. There's no one group out there that is responsible for a majority of the expenses. The expenses are cumulative of all of these things, and I would not suggest for a minute that we should have a cost containment strategy with regard to health care costs that focuses only on prescription drugs.

Ms. NEWLAND. But others have offered that, Congressman Jontz. There is some mention of that in your proposal to cap, or I don't have the exact verbiage, but place some sort of restriction on prescription drug prices.

Mr. JONTZ. My proposal is to cap all costs. I'm not—I wouldn't propose to single out prescription drugs at all, but the point is, I think, that you can't expect to be exempt from some attention because you're 5 percent of the overall costs.

Ms. NEWLAND. We did—the point was, Congressman Jontz, that when looking at the total health care picture, it seems somewhat ludicrous to focus on what is, in effect, the most cost effective piece, and one of the smallest pieces, and if a proposal were enacted to freeze prescription drug prices, the net gain would be higher drug costs—excuse me, higher health care costs in other areas because of the effect that would occur to research and development.

Mr. JONTZ. Well, you're—I'm just—it seems to me that none of these questions are going to go away until you can come forward with regard to the marketing costs, deal with the issue of the marketing practices, deal with the issue of the compensation of the executives. The marketing, I'm not opposed to paying executives well. I don't know how the compensation for your executives compares

to other companies. I don't have information that compares those, but from the industry standpoint, there has to be some better explanation of the marketing practices that are going on, whether those expenditures, whatever they are, and I have these industry-wide figures that are \$10 billion for marketing expenditures, sales and marketing together, for 1991, and that is close to a third of the total cost that we're talking about. If \$32 billion is the total expenditures on prescription drugs, we're talking about a third of it. So, it seems to me that's the question that has to be answered. We are not expecting all those answers to be a part of the record today. We appreciate that this dialogue is getting along.

I want to say in conclusion that thanks for your appearance today and for the seriousness with which the company has taken these inquiries, and we hope that this information can come out in the future, and I think that those things need to be addressed as we get into this debate on health care costs.

I want to thank all of the witnesses for an excellent hearing. The testimony was very helpful. I appreciate that many of you who are here in the audience today have views on these issues. I am hopeful that there will be many future opportunities for input by the public and by all effected parties as to how we can provide the best health care for the American people at an affordable price, and I look forward to discussing those issues with you in the future. With that comment, we'll call the hearing adjourned.

Thank you very much.

[Whereupon, the hearing was adjourned.]

APPENDIX



Eli Lilly and Company

Lilly Corporate Center
Indianapolis, Indiana 46285
(317) 276-2000

January 19, 1993

The Honorable Marilyn Lloyd
U.S. House Select Subcommittee
on Housing and Consumer Interests
2266 Rayburn House Office Building
Washington, D.C. 20515

Dear Congresswoman Lloyd:

This letter is in response to a request of Eli Lilly and Company for information made by Mr. Jim Jontz at a Select Committee on Aging (Prescription Drug Prices: A Bitter Pill to Swallow) hearing in Logansport, Indiana.

Mr. Jontz requested the following information:

1. An itemization of Lilly profits, and specifically, how capital expenditures are funded.
2. Lilly marketing expenditures.
3. The number of persons served and the expenditures for the Indigent Drug Program sponsored by Lilly.
4. Data on the history of Lilly wholesale prices.

The following information may be useful.

Profits and profitability

The profits of Eli Lilly and Company must fuel our future development. Historically, between 56 cents and 58 cents of each dollar of profit have been reinvested in the business. In 1991, 44% of the earnings per share was returned to the shareholders in the form of dividends. These shareholders' investments in our company are vital if we are to continue to survive in this research intensive, very risky business. The profits of our business fuel the future development of new, potentially life-saving drugs, for diseases such as

cancer or Alzheimer's. For example, we cannot go to a local bank and borrow \$800 million to fund our annual research and development budget. Therefore, our profits are the foundation of this development. Shareholders invest in this company what the banks will not. We must provide a return to the shareholders so that they will continue to invest in us.

Environmental efforts

In our efforts to comply with environmental regulations, we will need to continue to aggressively invest in capital projects over the next several years. Lilly sets high objectives for protecting the environment. In 1990-91, more than \$2 billion was invested by Lilly in capital projects related to research and development, manufacturing, environmental, and support facilities. Also, during the past five years, Lilly committed nearly \$600 million to the design, construction, and operation of its environmental protection systems. You may find the corporation's commitment to improving and protecting the environment outlined in the enclosed "Environmental Guidelines." Given every indication that environmental regulations will require an even greater financial commitment in the future, drug price controls would jeopardize our environmental responsibility efforts.

Marketing expenses

Eli Lilly and Company is a leader in providing a valuable educational service to physicians and pharmacists through its marketing programs. Lilly does not market its products directly to the patients but provides scientific information to the health care practitioners in an ethical and professional manner as provided for under FDA regulations. The majority of Lilly sales representatives hold degrees in pharmacy. The knowledge and training of our sales representatives provide them with the expertise to discuss complex pharmacological information such as product efficacy and proper drug use, etc., with physicians and pharmacists in a scientific and educational fashion. The educational materials used by our sales representatives undergo a rigorous medical and legal review prior to use. We believe you would find in talking to physicians and pharmacists that the educational and marketing efforts of Lilly are considered ethical, beneficial, and of the highest quality.

Indigent Drug Program

We want you to be aware that the Pharmaceutical Manufacturers Association, in response to numerous inquiries on the efforts of its member companies to address the availability of outpatient drugs to the indigent, published a directory of programs. Also, the Senate Committee on Aging published a similar report. (See enclosures).

Proprietary information

The specific expenses of our marketing programs, the Indigent Drug Program, and the history of our wholesale drug prices constitute proprietary information, and we are unable to provide it to you. As a publicly traded company, we have a duty to our shareholders. One of our most important duties to the shareholders is to protect the value of the company's assets, including proprietary information. Lilly publishes data on its sales and earnings on a quarterly and an annual basis. A copy of our 1991 annual report is enclosed. You will find additional data there.

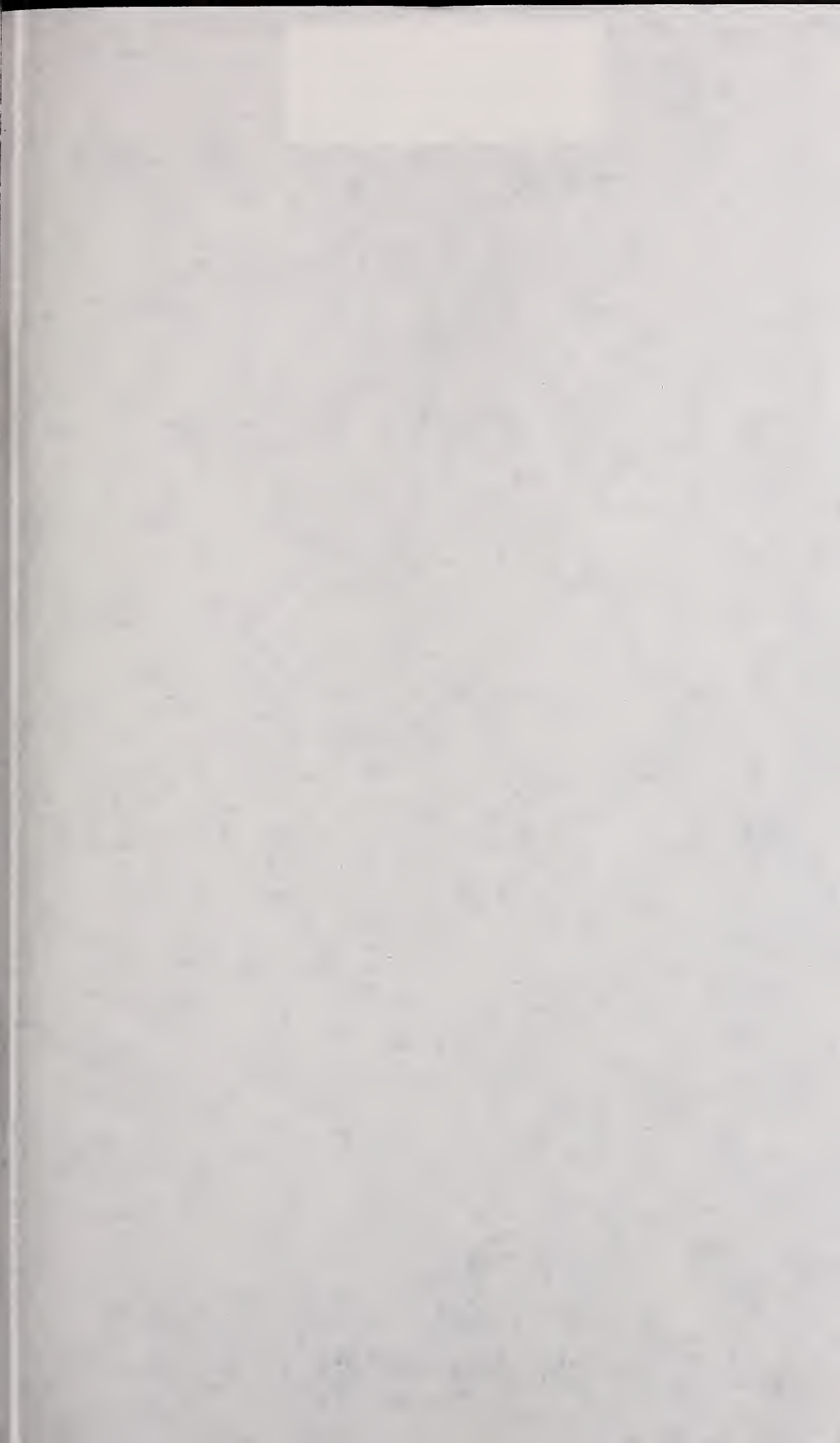
Please contact me if I may be of further assistance.

Sincerely,



Alecia A. DeCoudreaux, Director
Corporate Affairs

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